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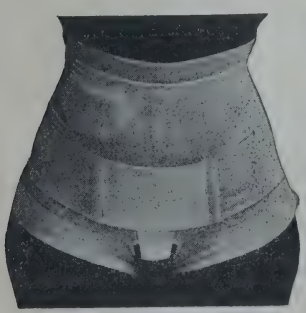

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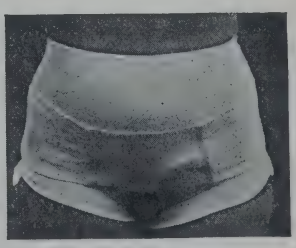

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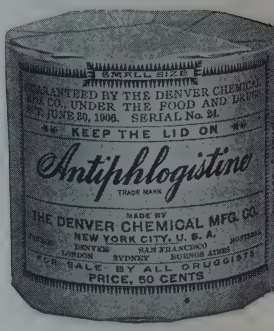

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THE HAHNEMANNIAN MONTHLY.

JANUARY, 1916

SOME ADDITIONAL OBSERVATIONS CONCERNING THE TREATMENT OF DIABETES.

BY

CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Reading, Pa., November 11, 1915).

In September, 1913, I read before the Homœopathic Medical Society of Pennsylvania, an essay on the treatment of diabetes. In this communication, I gave a review of my personal practice in the treatment of glycosuric cases, based upon the principles elaborated by Von Noorden and his followers. It will be of advantage to my hearers if I present at the outset of this address a general abstract of the communication to which I have referred.

1. Determine the condition of the patient at the time he comes under treatment by making a most complete examination both as to the history and the physical findings. In view of the many clinical ramifications of glycosuria as a symptom, it is of importance that the general examination of the patient shall be of a most searching character. As to the glycosuria itself, let the urinary examination be made after the patient has been on ordinary general diet for a period of two or three days. It is of the highest importance to weigh the patient and note his condition in this respect at frequent intervals throughout the care of the case.

2. After the determination of the patient's *status præsens*, he should be placed upon a standard diet for a period ranging

from three days to one week. During this period daily urinary examinations must be made, and careful watch maintained for signs of acidosis. Most of the standard diets recommended by prominent authorities are available for this purpose. It is foolish for the physician to construct a special one of his own devising for the mere sake of "being different." He is wiser if he will but direct his inventive faculties to other channels. Particular periods of the year may make it inconvenient to obtain certain of the articles prescribed excepting at a prohibitive price, when, of course, suitable substitutes may be made. Otherwise, I advise most strongly adherence to the known and tried. The standard diets advised were the following:

(a) THE VON NOORDEN STANDARD DIET AS USED BY THE STAFF OF JOHNS HOPKINS HOSPITAL: *Breakfast, 7.* 30 A. M.—200 c.c. (℥vj) of tea or coffee; 150 grammes (℥iv) of beefsteak, mutton chop (without bone), or boiled ham; one or two eggs.

Luncheon, 12.30 P. M.—200 grammes (℥vi) cold roast beef; 60 grammes celery (℥ij); fresh cucumbers or tomatoes with vinegar, olive oil, pepper and salt to taste; 20 c.c. (℥v) whiskey, with 400 c.c. (℥xiii) water; 60 c.c. (℥ij) coffee without milk or sugar.

Dinner, 6 P. M.—200 c.c. clear bouillon; 250 grammes (℥viiss) roast beef; 10 grammes of butter (℥ijss); 80 grammes (℥ij) green salad with 10 grammes (℥ijss) vinegar and 20 grammes (℥v) olive oil, or three tablespoonfuls of some well-cooked green vegetable, three sardines a l'huille; 20 c.c. (℥v) whisky with 400 c.c. (℥xiij) water.

Supper, 9 P.M.—Two eggs; 400 c.c. (℥xiij) water.

(b) THE JANEWAY DIET LIST IN USE AT THE PRESBYTERIAN HOSPITAL, NEW YORK: *Breakfast.*—2 eggs; ham, 90 grm. (3 oz.); coffee with 45 grm. (1½ oz.) cream; butter, 15 grm. (½ oz.) on the biscuit during the test period; cooked with the eggs if no biscuit or bread is taken.

Luncheon.—Meat, 120 grm. (4 oz.); green vegetables from list, 2 tablespoonfuls; white wine, 2 claret glasses (6 oz.) or whisky or brandy, 1 oz.; butter, 15 grm. (½ oz.), with the green vegetable if no biscuit or bread is taken.

Afternoon tea with 15 grm. (½ oz.) cream.

Dinner.—Any clear soup; fish, 90 grm. (3 oz.); meat (beef, turkey, or chicken) 121 grm. (¼ lb.); green vegetables from

list, 2 tablespoonfuls; salad with 15 grm. (½ oz.) oil in the dressing; cream cheese, 30 grm. (1 oz.); white wine, 6 oz.; whisky or brandy, 1 oz.; demi-tasse of coffee; butter, 30 grm. (1 oz.) on the fish, meat, and green vegetables if no bread or biscuit is taken.

Bed Time.—Bouillon with 1 raw egg.

(c) BASSLER'S STANDARD DIET IS AS FOLLOWS: *Breakfast.*—Coffee with 1½ oz. of cream; 2 eggs with ½ oz. of butter; bacon, 1 oz.

Luncheon.—2 eggs; bacon, 1 oz.; 2 ounces of lamb chops, ham, steak, chicken, or fish broiled with butter (½ oz.); vegetables from list; wine, 6 oz.; or whisky, 1 oz. with water.

Dinner.—Any clear soup; 4 oz. of roast pork, beef, mutton, turkey, chicken, lamb; green vegetables; salad with half oz. of oil dressing; 1 oz. of cream cheese; wine, 6 oz.; whisky, 1 oz.; coffee.

As part of my former paper was incorporated a list of foods graded according to their carbohydrate content as follows:

Food containing 5% or less of carbohydrate: Lettuce, spinach, sauer-kraut, string beans, celery, asparagus, cucumbers, Brussels sprouts, sorrel, endive, plain pickles, ripe olives, grape fruit, cauliflower, tomatoes, rhubarb, egg plant, leeks, beet greens, watercress, butternuts, clams, scallops, and fish roe.

6% or less: Cabbage, radishes, pumpkins, kohl rabbi, oysters, liver.

10% approximately: Onions, squash, turnip, carrots, okra, beets, mushrooms, lemons, oranges, cranberries, strawberries, blackberries, gooseberries, peaches, pineapple, watermelon, muskmelon.

15% approximately: Green peas, artichokes, parsnips, canned lima beans, apples, pears, apricots, cherries, currants, raspberries, huckleberries, pecans, filberts, walnuts, pistachios, and beechnuts.

20% and over: Potatoes, shell beans, baked beans, green corn, boiled rice, boiled macaroni, plums, bananas, and almonds.

It will be observed that the above lists are notable for their freedom from patented foods, gluten bread, saccharine, and other substances having a traditional reputation in diabetes. I condemned them two years ago, and still hold to the opinion then expressed.

3. In a large proportion of the cases, the urine became sugar

free in a period ranging from 36 to 72 hours. The standard diet may be continued for a few days longer, after which the patient's tolerance is to be tested. For this purpose, the best carbohydrate food is ordinary good wheat bread, such as the patient likes and must have if he is to be happy. Ounce after ounce of that substance is added to the standard diet each additional two days until sugar reappears in the urine. The tolerance for bread having been established, the patient is now permitted to indulge in a daily allowance of two-thirds of the maximum amount taken, the urine remaining sugar free. In advising diet thereafter in order to give the patient a suitable variety, it was suggested that various carbohydrate foods could be substituted for a portion of the bread according to their carbohydrate content. For example, potatoes and rice possessing one-half the carbohydrate content of good wheat bread may be substituted in the proportion of two ounces of either for one ounce of bread.

4. Should signs of acidosis intervene, the patient must be placed at once upon an exclusive carbohydrate diet and bicarbonate of soda administered in enormous doses, even to the extent of three or four ounces daily. Ten or fifteen grain doses three times daily are utterly useless. Following the return of the patient to his previous condition, various dietetic plans may be followed.

5. If tolerance is not satisfactory or signs of acidosis threaten, we may place the patient upon the Von Noorden oatmeal diet, or the Mosso potato cure, or the Strauss rice diet. Each of these carries out the same principle, namely subsistence for a few days upon some one particular carbohydrate food. Attempts should not be made to improve upon either of the authorities by mixing the foods, for their value depends upon the limitation of the diet to just the one carbohydrate. Following the carbohydrate days (usually four or five) the patient's tolerance may be tested once more, and usually it will be found to have increased. The influence of the oat meal diet may be to produce a temporary increase in the glycosuria, following which that phenomenon diminishes markedly. It may however cause a complete disappearance of that symptom. The oat-meal diet is prepared as follows: 8 oz. of oat-meal is cooked thoroughly in a double boiler for at least three hours with a minimum addition of water. Towards the end of the cooking, 8 oz. of butter are added with salt and pepper to

suit the patient's taste. This constitutes the daily allowance of food. In addition the patient should take plain coffee; light white wine 8 oz. or cognac, 2 oz. The white of six eggs may be added to the oat-meal porridge if desired. The entire diet consists of protein, 63 grm. (2 oz.); nitrogen, 16.8 grm. (½ oz.); carbohydrate, 170 grm. (5 2/3 oz.); fat, 212 grm. (7 oz.); total calories, 3300.

Following upon the oat-meal days, the patient's tolerance is to be tested once more, and almost invariably, it is found to have been increased, and a moderately severe case of diabetes to have been converted into a mild one. Subsequently the patient is to be submitted to oat-meal periods according to the judgment of the physician as dictated by the progress of the illness.

The days of carbohydrate feeding must not be looked upon as anything else than indicated by the words "days of carbohydrate feeding." The exclusive carbohydrate is for the purpose of increasing tolerance, and is not a permanent system of feeding.

6. As an alternative diet to increase tolerance, and to diminish acidosis, we have the so-called green days. The rationale of this temporary diet is its ability to give rest to the metabolic functions, and thus raise the tolerance of sugars made from the proteins. The articles comprising the list for the day include straight coffee, bacon in small quantities, one or two eggs, spinach, lettuce, asparagus, tea, and whisky (the latter in small quantity.) The nutritive value of this diet is very low, and is practically a starvation diet which puts something solid into the stomach.

The following is a sample diet list for a green day as proposed by Janeway;

Breakfast.—1 egg, boiled or poached; cup of black coffee.

Dinner.—Spinach with hard boiled egg; one-half ounce of bacon; salad with half ounce of olive oil; 4 ounces of white wine or one ounce of whisky or brandy.

4.30 P. M.—Cup of beef tea or chicken broth.

Supper.—1 egg, scrambled with tomato and a little butter; bacon, one-half ounce; cabbage, cauliflower, sauerkraut, string beans or asparagus; white wine 4 ounces, or one ounce of brandy or whisky.

7. In some of the severe cases of diabetes, it is evident that

sugar is formed from the proteid food in which case, the so-called limited protein diet of the Presbyterian Hospital, New York, may be prescribed. It is as follows:

Breakfast.—2 eggs; bacon, one-half ounce; coffee with one and half ounces of cream; butter, two-thirds of an ounce.

Luncheon.—1 egg; bacon, one-half ounce; meat, 2 ounces; salad with one-half ounce of oil in the dressing; white wine, 2 claret glasses, or one ounce of whisky or brandy; butter, one and one-third ounce.

Afternoon.—Tea with one-half ounce of cream.

Dinner.—Any clear soup; meat, 3 ounces; vegetables from list, 2 tablespoonfuls; salad with one-half ounce of oil in the dressing; cream cheese, one ounce; white wine, 6 ounces, or whisky or brandy, one ounce; demi tasse of coffee; butter, one ounce.

Bedtime.—Bouillon with 1 raw egg.

This diet may be continued in the cases in which it is indicated for an indefinite period, providing a judicious addition of carbohydrate food be permitted. Experience with the individual patient is our only guide in determining as to the proper balance of proteid and carbohydrate food. I have seen sugar disappear on this diet when the standard Von Noorden diet failed.

8. Cases of diabetes cannot be treated according to any set formula. There are hardly two cases alike in their clinical phases. Individualization is absolutely necessary in treatment. In many cases, the treatment must be an intelligent experimentation along the lines above indicated. Attention to details is absolutely necessary. The supervision of the patient must rest with the physician in charge exclusively. He must give the same faithful care and interest to the diabetic that he gives to cases of typhoid fever, lobar pneumonia, and other acute illnesses. This means examinations at intervals of 24 to 48 hours until tolerance is determined and the patient thoroughly studied. Urinary analyses must be made by the physician himself, and not relegated to outside authorities from whom reports cannot be received without a necessary delay which is fateful to good results.

9. Two years ago, I wrote "Throughout the course of the treatment no matter what may be the plan adopted, close watch should be kept upon the patient's weight, for no course of

treatment can be regarded as progressing favorably if the patient's weight is not maintained or is increasing. I still hold to this opinion. For several days during and following the standard diet, a loss of weight is not unusual, in fact may be expected, but with fair tolerance the patient soon regains his normal standard and maintains it. It is never sufficient to name the articles of food which the patient may or may not take, but it is absolutely essential to specify the daily amounts of each. In other words, until the patient has had experience with treatment, he must live by the scales.

10. In my former paper I said something about the value of rest, and spoke of the importance of exhaustion or fatigue as a cause of acidosis, as taught by my colleague, Dr. O. S. Haines. At the present time, I am more firmly convinced than ever of the importance of rest. It seems to explain the great improvement of the patients in the hospital wards. To my mind, it is one of the most important elements of success in the Allen treatment, to which reference will be made at the close of this paper.

Within the past two years, it has been my fortune to examine several cases of glycosuria which well illustrate the necessity of individualizing cases. One year ago, there was admitted to the surgical wards of Hahnemann Hospital, service of Dr. W. B. Van Lennep, an Italian woman with severe cholecystitis. In the course of the systematic examination in vogue in the hospital glycosuria with diaceturia was discovered. Standard diet failed to eliminate the sugar from the urine. Thereupon I was consulted. The oat-meal diet was then prescribed, and was utterly useless in every respect. Bicarbonate of soda was administered in substantial dosage, and as the patient was getting worse, operation as originally determined was advised. Following upon the same, two per cent. bicarbonate of soda was added to the normal saline for the Murphy enteroclysis, and recovery proceeded without a ripple. Glycosuria and diaceturia promptly disappeared, and the patient left the hospital apparently well in every respect. Murphy in his *Clinics,* reported a case of glycosuria which recovered following drainage of the gall bladder. These experiences together with one which I shall next narrate suggest attention to this particular organ in all patients with so-called diabetes.

About five years ago, a colleague brought to me for advice a mild diabetic, the glycosuria having been discovered in the

course of a systematic examination following an injury to the foot. This patient made a very good recovery, and remained well until eighteen months ago when he was attacked by acute cholecystitis from which he recovered without operation. There was no return of the glycosuria, however.

One of my most successful cases was a man aged 45 treated five years ago. His urine remained free from sugar until last May, at which time he met with a severe automobile accident, and the sugar returned. He came to Philadelphia in August to undergo treatment. When he suspended treatment at hospital five years ago, his tolerance for bread amounted to 16 ounces. This time, the sugar was removed from the urine in 48 hours by standard diet, but his bread tolerance amounted to but 3 ounces. The Von Noorden oat-meal diet was prescribed for three days. Following this the sugar disappeared entirely and did not return when he had taken as much as 7 ounces of bread daily. He was then permitted to go home with an allowance of carbohydrate food equivalent to 4 ounces of bread daily. Thus far the glycosuria has not returned.

A patient aged 50 years was referred to me by Dr. W. C. Barker. The sugar was readily eliminated by standard diet, but tolerance was poor. The patient was not amenable to discipline. Business was always with him more important than health. The interesting point in this case was the low specific gravity of the urine which reduced the copper in the test solution even when its gravity was as low as 1003. Before instituting treatment the gravity was high, 1030; the sugar by fermentation, 2%. It is doubtful if the reducing substance when the gravity was low was really glucose. I know of no report in medical literature of any lower specific gravity than 1010 with glycosuria. The copper reduction took place rather suddenly after the solution has been boiling a few seconds. Glucose does not behave in this way. The patient abandoned treatment before an opportunity for a more exact analysis was had.*

A patient was admitted to my wards in Hahnemann Hospital by Dr. Bickley. All the clinical phenomena, the symptoms, history, laboratory analyses, and the X-ray serials pointed to carcinoma of the stomach, but she had a glycosuria amounting to 3%. According to Dr. Bickley's experience with her the glycosuria antedated the gastric symptoms. The case was

*This patient has since died. I do not know the late particulars of his illness.

hardly considered a good one for operation; but as I felt there might be a chance with operation, and everything was hopeless without one, operation was performed by Dr. H. L. Northrop. Carcinoma of the pylorus with apparently secondary involvement of the head of the pancreas was found. But for the pancreatic involvement the case was an ideal one for resection of the pylorus. A gastro-enterostomy was performed; but the patient died.

A man aged 58 came to me with 5% sugar in his urine. The result of standard diet was prompt and uneventful. Tolerance was low, only five ounces of bread daily. The reaction on the return of the positive testing was peculiar, and showed that the glycosuria was also a pentosuria. At the same time he began to gain rapidly in weight, which in the course of a few days was determined to be due to a rapidly accumulating ascites. He was finally tapped, and following the removal of the fluid, an ill-defined tumor was discovered in the region of the gall bladder. Next he became jaundiced. Finally an exploration was performed by Dr. W. B. Van Lennep, and malignant disease of the gall bladder discovered. The patient did well for three or four days following the operation, and then retrograded, and died in six days following operation.

A very interesting case is one which I have had an opportunity of examining and treating over a year. In the beginning, it was impossible to remove the sugar from the urine by standard diet and with the dieting, diaceturia became more pronounced than before. Five days of oat-meal diet brought about some amelioration of conditions in the way of lessening both glycosuria and diaceturia, the sugar dropping from 8% to less than 1%, and diaceturia became negligible. Next the limited protein diet was prescribed, and to this two ounces of bread or its carbohydrate equivalent were added each day. During the past summer, the patient was seized with an obstinate diarrhœa, which was quite profuse. She was ordered to bed and treated according to ordinary methods without changing the diet. This not helping her, arrow root gruel, boiled milk, milk toast, dry toast, boiled rice, were prescribed, and *mirabile dictu,* the glycosuria disappeared for several days. With establishment of normal bowel action, the glycosuria became as bad as ever. The patient is at present feeling well so far as symptoms are concerned, but has her glycosuria to the extent of a little over 1%. What caused the disappearance of the glyco-

suria? The diarrhœa, the rest in bed, or the change to the strict carbohydrate diet? I have no doubt that the former two were the important factors. In this case the exclusive rice diet has been found to be much more efficient in getting rid of the diaceturia than is the oat meal regime of Von Noorden.

Within the year there has been introduced a new treatment for diabetes known after its discoverer, as the Allen treatment. Briefly it consists in ordering the patient to bed, and denying all food of any kind whatsoever until sugar disappears from the urine. Following this tolerance is tested, but in a somewhat different way from that advocated by Von Noorden and his followers. The essential detail is the very gradual increase of carbohydrate permitted day by day, and the employment of vegetables from the five and ten percent classes for the purpose. The principle upon which the treatment has been founded is that of the Von Noorden green day, which as already stated is but a limited starvation plan, and "gives rest to the metabolic functions and thus raises the tolerance of sugars made from the proteins."

Its advocates are wildly enthusiastic over it, and make claims that are almost unbelievable. The treatment necessarily gives rise to considerable loss of strength and weight, which they regard as of no importance whatever. Herein they are at variance with all established precedent. The only advantage that I can see from the weakness thus occasioned is the obvious necessity on the part of the patient lessening his physical and mental activities. The testing of the patient's tolerance being accomplished by the daily addition of vegetables from the 5% class at first, and later from the 10% class, the process is necessarily slow, and indeed occupies the patient's attention so thoroughly as to make him readily amenable to discipline. The absolute rest rendered necessary during the period of starvation is not without its therapeutic effect. We have noticed in our ward cases that the sugar percentage not infrequently drops one-half on rest alone. At my request, Dr. G. Morris Golden tried this treatment on two cases in Hahnemann Hospital wards. Both were bad ones with gangrene. The sugar disappeared from the urine as predicted by the originator, and that too without diaceturia. Although sugar returned in both when foods from the 20% class were prescribed, Golden was favorably impressed with the treatment. From what I can see, the Allen treatment is well worthy of professional confi-

dence, but it is not a cure-all by any manner of means, nor will it relieve the patient of more or less constant medical supervision. It is simply a good plan to try in some cases, and I might add in the especially bad ones.

In closing, let me plead with you as clinicians to pay attention to the diabetic. There is every reason why you should take up the matter. In the past, the plans of treatment in vogue probably did as much harm as good and naturally became discredited. The family practitioner is well equipped for the work. His only possible objection to it is that it is time consuming. As medicine is now practised, and as medical science is advancing, all medical work takes time and labor. I am sure that the public will appreciate your efforts. If you do not undertake the matter, your patients will surely drift to others and especially to the younger men who are now being taught modern methods in our colleges and hospitals. At the present time there are no less than six diabetics in my wards at Hahnemann Hospital, and the medical section at work numbers just five senior students. Each of these men has the opportunity of observing the progress of each and all of the cases. It is needless for me to remind you of the experience in this disease with which they will go to the public for patronage. The diabetic public is not as yet aware of the help awaiting them if they but make an intelligent battle for health; while now in the depths of fear of the future, they have recourse to patent diabetic foods and patent medicines, a practice which we can stop as soon as we demonstrate our ability.

THE BIOLOGICAL CO-RELATION OF THE LAW OF SIMILARS.*

BY

RALPH R. MELLON, M.SC., M.D., ANN ARBOR, MICH.

My sole intention in pointing out some biological co-relations of the Law of Similars is a two fold one: First to show that we are not wrong in defending this principle until such time as it meets adequate recognition, and second that we are wrong when we neglect to develop those branches of knowledge which are almost conditional to its most perfect application.

If this principle is a broad one, as we believe it to be, it

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must have a far reaching correspondence with many other laws in our Universe. This is so fundamental that it requires no elaboration. It is perfectly logical then, that because of its ramifications we cannot isolate it, and he who would make the attempt, only becomes ridiculous.

We believe it to be the safest and best therapeutic principle in existence. Even so, we have seen it fail in enough instances to wish many times that we had a better guide. I do not intend to discuss the many factors which might enter into an answer to the query "Why do prescriptions so often fall short of the mark?" I merely want to impress on you my first contention, viz., that we hit the mark often enough, to know that we have something which is capable of infinitely more development. I do not wish at this point to enter into a polemic with the man who has never lost a case, or who has cured 99 per cent of his curable cases.

It is practically certain that Dalton as a result of his study of Isaac Newton's works, conceived the atomic theory of chemistry in his own mind without a shred of experimental evidence. He then proceeded by deduction, made surprisingly few experiments, found that they corresponded to his preconceived ideas, and one of the most beautiful and useful classification systems ever evolved by the mind of man was fairly launched.

Those of you who are at all familiar with relatively recent developments of chemistry, know that Vant Hoff's generalization regarding solutions is the greatest ever made in this field. This discovery of regularities came likewise as a result of very little experimental evidence, although subsequent work has corroborated this observer's work. Surely Hahnemann as a scientist does not suffer by comparison with these men, when one considers that he worked for fifteen years to validate his hypothesis before publishing anything.

Just what are some of the co-relations of the Law of Similars or its application? I will mention first: the theory of electrolytic dissociation. This theory states that certain substances in dilute solutions are split up or dissociated with a result that from a physical and chemical standpoint the solution is much more active. The further a dilution is increased, the more active chemically it becomes, until a maximum is reached *i. e.*, until the substance is completely dissociated.

The chief difference between a dissociated and non-dissociat-

ed atom is the charge of electricity carried by the former. For example, an atom of sodium carrying a unit of electricity is something wholly different from the metal itself. The addition of this electricity changes its properties fundamentally, and it is justifiable to consider the sodium ions as an allotropic modification of the element in the same way that graphite, charcoal and diamond are all allotropic modifications of the element carbon.

It is superfluous in a gathering of this kind to point out the relation of this proposition to homœopathic therapeutics. In justice to the theory, it should be mentioned that not all chemical compounds are capable of dissociation and likewise we know that not all remedies can be successfully diluted for therapeutic purposes.

Second: The subject of colloidal chemistry is so interesting that I am constrained to draw a parallel between the action of colloids and homœopathic dilutions from a somewhat different standpoint than the above.

It is of course well known that certain metals and other substances that are insoluble in water can be suspended in such finely divided condition that the particles do not fall to the bottom of the liquid. An element thus finely divided is said to be in the colloidal condition. These particles are ultramicroscopic, but can be observed as shining diffraction discs, in vigorous brownian movement by the ultramicroscope of Siedentopf.

If we now consider in what respect the particles, say, in a colloidal solution of platinum prepared by Bredig's method of an arc between platinum electrodes under water differ from an equal amount of the metal in the form of sheet or wire immersed in water, it is plain that it consists in the relative enormous development of surface in the former case. According to Siedentopf and Zsigmondy the particles in certain colloidal solutions of gold have a radius of one millionth of a c.c.; a sphere of gold with a radius of one m.m. if divided into particles of those dimensions would have a surface of some 100 square meters.

Enzymes are colloids, and although they have not as yet been demonstrated to have definite chemical constitution, they have a very strong similarity in their action to bodies in inorganic chemistry known as catalyzers, and these do have a definite constitution.

The two cardinal characteristics of both enzymes and most catalyzers are: First, their marvelous acceleration of a chemical reaction, and second, the fact that at the end of that reaction, they remain unchanged. We understand in some cases the cause of these accelerations by minute quantities of a known chemical. The action of electrolytes on colloids (enzymes) is interesting. Ptyalin action is almost nil, in the absence of Na Cl. And Bordet has shown that agglutination does not proceed in the absence of this salt. Pepsin is inactive without hydrioxion. Amylase of the liver is completely inert without the presence of the neutral salts.

Third: But in the science of immunity one can find constant illustrations of the Law of Similars. Vaccines and serums can surely be considered as good homœopathy. The gulf between true therapeutics on the one hand, and diagnosis and pathology on the other, has been bridged over by the science of immunity. This bridge may not be visible to every one, but surely, even the casual observer can make out a span or so in the uncertain light projected by medical evolution. I might say that the science of immunity is the meeting ground for pathology and therapeutics. Its development must demonstrate the futility of attempting to use the microscopical tissue lesion as a guide to prescription, but it will also show us why attempts at prescribing for some things is also futile.

My thesis is: Pathology has been inimical to homœopathic therapeutics because the former contended that its findings could be used as a guide in prescription. Immunity, although a development of pathology, goes behind the microscopical lesion, and its province, from a practical standpoint, is in no way connected with visible cellular pathology. In this respect it touches very closely on the sphere of action of the Law of Similars.

The process of immunity does not produce tissue damage, and the vast majority of all immunity reactions do not produce changes in the organs recognizable with the microscope. Concrete examples of this contention are on the increase. The most classical, of course, is the evolution of tuberculin therapy. It is so well known that I hesitate to bore you by reference to it. You are all familiar with the damage it did when given in the hope of mechanically evacuating the lesion as one might use a cathartic. This was Koch's idea, and was based on the areas of coagulation necrosis produced by injection of the

tubercular products. And it is the commonest of knowledge that the therapy of today precludes any reaction by ordinary methods. The dose used is entirely subphysiological in the commonly accepted sense of that term.

And of equal importance is the introduction of the principle of sensitization, in the sense of Bordet and Ehrlich, into typhoid therapy. The live organism is treated with an immune serum, which is later washed off, and the organism so sensitized is injected without further treatment. The antigen has united with its antibody in the immune serum, and the neutralization of its toxic portion prevents the local and constitutional reaction which has been a prominent and distasteful feature of the inoculations. The degree of immunity produced is much greater both experimentally and practically, than by the other method. Gay goes a step farther, and extracts the non-immune portion with absolute alcohol leaving only the immune part, which he claims produces even a better grade of protective power.

As the science develops, these instances will multiply. It has occurred many times to me in my experience with vaccines that the immunity so desired was produced in spite of the reaction, rather than because of it, and as methods of preparing vaccines were perfected, we must undoubtedly eradicate the negative proposition of Wright. In vaccine therapy the negative phase is identical with our dose of a remedy which causes an aggravation of the symptoms. And I have the temerity to believe that in the future, developments will show an absence of reaction of any kind after the administration of vaccines. Such dosage will be very much like what we now use, and whether the newer methods will be more effective can only be answered by the future.

The Law of Similars is a broad biological generalization, application of which has been successfully made for more than 150 years. Many researches from modern science corroborate the validity of this idea, rather than disprove it. This is perfectly evident to anyone who has given the matter any thought at all. Because the Law of Similars does not hold with the mathematical accuracy that is expected by some, is no reason for loss of faith in regard to it. Many of the laws in the supposedly accurate sciences are by no means applicable under all conditions. Permit me to refer briefly to the gas laws, viz., those of Boyle and Gay Lussac. The former states that

the volume of a gas varies inversely as the pressure when the temperature is constant. Formulated, pv equals K.T., when p is the pressure and v is the volume. K is a constant, and T is the absolute temperature. Concretely, when one doubles the pressure, he halves the volume. This sounds as concise as 2 times 2 equals 4. Exactly 4 and not a fraction above or under 4. A closer investigation of the facts in the case show that the variations from this generalization are considerable, for reasons which are quite obvious. A little reflection will enable one to see that a gas is much more compressible when near its point of condensation, and not compressible enough when under high pressure.

This proposition can readily be proven by subjecting gases to varying pressure. Instead of the volume into the pressure being a constant, the curve when charted shows nothing like that. So, although from a practical standpoint, the gas laws as formulated did apply in most cases, yet in many, they were inaccurate. A correction in them has been introduced by Van der Waal's which has made them much more accurate under both low and high pressure, but from a strictly mathematical viewpoint, they are not infallible yet, and probably never will be.

So the Law of Similars or any other biological law will only be a broad generalization, and infinitely more so than the cited parallel, for the very simple reason that we are dealing with a large number of factors, only a few of which we can apprehend. One may gain some appreciation of this fact by considering a single biological reaction, the Wassermann or most any serum reaction. Application of scientific methods for the quantitative estimation of antibodies approaches mathematical accuracy. In the minds of some, the results are nearly absolute, but such convictions are usually reached by the uninitiated. No serum reaction can be accurate only in a certain per cent of cases, and in many instances must only be regarded as symptoms which should be incorporated in the entire complex before we are able to arrive at correct notions.

Guinea pig serum which contains the activating something which makes possible the well known phenomenon of hemolysis in the Wassermann reaction, can be entirely inactivated by shaking it vigorously. This has been found to be due to the old, old physical phenomenon of surface tension, and the addition of anything which lowers this tension, prevents inactiva-

tion. This merely illustrates that in such a well known test, we are dealing with many factors the significance of which we are just beginning to realize.

Again this reaction, like all others when first discovered, was supposed to be specific. We know now that it is far from being so. The Abderhalden test for pregnancy supposed by him to be specific will eventually be shown not to be so.

But even though the Law of Similars has served us so well, it does not follow for a minute that its applications cannot be amplified and improved. Conservative vaccine and serum therapy are scientific developments of the Law of Similars, and in this new science, we are approaching nearer ultimate causes in a biological way than we have ever gotten before.

Some work has been done in bridging over the gulf existent between the antigenic powers of inorganic and organic chemical compounds and those of bacteria. Only a start has been made in this direction. But from the instances cited where homœopathy touches on so much that is being done in science today, it seems more than ever imperative that our colleges and our hospitals scattered over the country should have pathological departments where the material in those institutions is utilized for studying the science of immunity and thus improving the homœopathy that we have today. If homœopathy is so intimately connected with immunity and the processes of physical chemistry, and the sciences which are fundamental to it, a greater responsibility devolves upon us than we seem to have realized. If we are to progress in the applications of our law, why is it necessary to wait until the opposition works out methods that we will later be compelled to appropriate?

At certain times, I am privileged to visit large and prosperous homœopathic hospitals in our cities. It is with a great deal of regret that so far I have been unable to find well organized laboratory departments. Cities like Rochester and Buffalo, N. Y., and many others where homœopathy is strong should have laboratory departments to their hospitals with enthusiastic, ambitious men grappling with some of the thousands of problems that confront us today. Such departments should have a pathologist, a bacteriologist, and a biological chemist all co-operating in the routine work of that hospital and thus serving the patient and the clinician. They should also be doing the larger work, viz., the utilization of the cases

for the study of medical problems and for a thorough testing out of our homœopathic drugs with the many methods which are at their command. To be concrete: What an opportunity for the investigation and study of that bugbear of medicine, idiosyncrasy. Drug allergies, food allergies, pollen allergies, as we are prone to style them now. We are no longer so totally ignorant regarding idiosyncrasy as we once were. An extremely interesting case of food allergy is reported by Schloss in the *Medical Record* of 1912. His experiments were reported on a boy patient seven years of age. When this patient was ten days old he was given some egg white for diarrhœa, with no ill effect. The second time that the child ingested egg, months later, he developed urticarial lesions around the mouth, swelling of the buccal mucosa and vomiting. The child became comatose, and fear for his recovery was entertained. Since that time the slightest amount of ingested egg sufficed to produce urticaria wheals around the mouth, with swelling of the buccal mucosa, and occasional vomiting. Here then, was a case of marked idiosyncrasy to egg following an intial sensitization of the organism. In addition to his hypersusceptibility to egg, it was noted that this child was also hypersensitive to almonds and oat meal. Schloss' experiments were chemical, biological and therapeutic. He succeeded in demonstrating that it was the ovo-mucoid in the egg white to which the child was most sensitive, and the proteose of the almonds and oatmeal.

With the blood serum of the patient, he was able to produce anaphylactic phenomena in guinea pigs by injections later of solutions of ovo-mucoid. Of great interest, moreover, was the fact that with dilute solutions of ovo-mucoid, almond and oatmeal proteose he was able to provoke urticarial lesions in the patient by abrading the skin by means of a Von Pirquet borer. These reactions Schloss showed to be entirely specific. Of still greater importance, certainly from the standpoint of the patient, was the fact that by administering very small and gradually increasing doses of ovo-mucoid in capsule form, Schloss was able to immunize the patient absolutely, so that at the present time, eggs in any form are tolerated. It is of peculiar interest to note that this treatment also established complete immunity to oatmeal and a lessened susceptibility to almonds.

Such work as this requires men who have devoted much time

and study to their subject. The work is intimately related to the best homœopathy. Why should our opponents have investigating staffs in their hospitals, large endowments, etc., while we do almost nothing of an advancing nature in the work so akin to our guiding star? I consider these questions as vital ones, ones that must be dealt with, and the obstacles they represent overcome, if our school will continue to be a factor in medicine in this country. We have talked a lot in the past, and are yet talking about drug proving. I should like to restate my convictions which I have so often expounded. Vague ramblings and dreams, and ruminations about drug proving never accomplished anything, and although this aspect of my paper has been placed last, it must be the Alpha practically, or all the papers we read and all the talk we do and all the beating of the air about the Law of Similars will scarcely repay us for the energy we spend.

"A man, not of the common clay,
But who had dreamed his life away,
Conscious of kinship with the great
Knocked fearlessly at Heaven's gate;
Admitted there, he straight way caught,
The circle of those minds whose thought
Had been his own. Not recognized
By those whose company he prized,
Disconsolate, he went away,
And then he heard an angel say,
'Here, as on earth, you find yourself alone,
Because by works, not thoughts, the man is known.'"

ANALYSIS OF DRINKING WATER.

BY

WILLIAM A. PEARSON, PH.C., PH.D., M.D.

Professor of Chemistry, Hahnemann Medical College of Philadelphia.

(Read before the Southern Homœopathic Medical Association at Cincinnati, November 9, 1915).

PHYSICIANS are frequently consulted concerning the danger of drinking water from various sources. In cases where the medicinal action of the water is only concerned and the chemical composition of the water is known, the physician usually

gives accurate advice. Unfortunately this is not always the case when an opinion is expressed concerning the actual danger of drinking water from a water supply, even when a sanitary analysis of the water is available.

In the first place, a sanitary analysis of water is intended primarily to determine the extent of contamination, the purity of the water and the danger of using it for drinking purposes. It is perfectly evident that even an accurate determination of the salts present in the water does not give this information. It is now established beyond question that certain "zymotic" diseases may be transmitted through the water supply. Typhoid fever, Asiatic cholera and dysentery are certainly frequently propagated by this means. Even if the etiologic cause of the disease is well known, it is seldom that the micro-organism responsible for the disease can be isolated from the water because of the presence of myriads of other micro-organisms. In fact bacillus typhosus has only been isolated a few times by the most competent bacteriologists from water known to be contaminated with these micro-organisms.

When the courts were discussing the water supply of St. Louis and the possible contamination by the sewage from Chicago, great difficulty was encountered in identifying a peculiar type of bacillus prodigiosus, although actually barrels of the culture of this micro-organism had purposely been placed in the sewers at Chicago. It is evident therefore that a bacteriological examination of water will not give the desired information.

Since we cannot determine the dangerous character of a water by estimating the chemical salts or by a bacteriologic examination, evidences of contamination are indirectly determined by estimating accurately the products of protein decomposition. Certain it is we can have no contamination if the water is perfectly free from proteins and the products of protein decomposition because the micro-organisms are themselves protein in character and require similar substances for growth. A common error in interpreting a sanitary analysis of water is due to a failure to understand that the small quantities of substances reported are not in themselves responsible for the dangerous character of the water. No one would consider the small amount of protein in a tube of a bouillon culture of bacillus typhosus dangerous to human life, yet if we knew that the amount of protein present was in proportion to the number of micro-organisms, we would place the true significance on this determination.

DECOMPOSITION PRODUCTS OF PROTEINS.

Most of the complex protein molecule is a union of various amido acids. This is possible because amido acids are both acidic and basic, due to the simultaneous presence in each one of an acid group (carboxyl—COOH) and a basic group (amidogen—NH^2). As proteins decompose, the nitrogen is combined in less and less complex form. First, as "albuminoid ammonia," then in succession, "free ammonia," nitrites and nitrates. It is perfectly evident that natural water cannot be obtained for drinking purposes absolutely free from organic contamination, hence certain standards for permissible amounts of these products of decomposition have been proposed. The amount of nitrogen combined in each form is accurately determined and the results compared with permissible standards.

These determinations are quite tedious and complicated and no details of the standard analytic methods will be given as these may be readily found by consulting the book published by The American Health Association, entitled, "Standard Methods of Water Analysis."

Besides the determination of the various nitrogen compounds certain other determinations are made which have a relation to contamination. A list of the important determinations that should be made for a sanitary analysis follows, together with permissible standards.

Total solids—not over 500 parts per million.

Organic matter (determined by ignition)—not over half the total solids.

Oxygen required to oxidize the organic matter—not over 0.3 part per million.

Nitrogen as "albuminoid ammonia"—not over 0.2 part per million.

Nitrogen as "free ammonia"—not over 0.12 part per million.

Nitrogen as "nitrites"—not over 0.02 part per million.

Nitrites are usually evidence of existing putrefactive changes and nitrates the final products.

Nitrogen as "nitrates"—not over 5 parts per million.

Chlorine (cl.)—not over 10 parts per million.

Phosphates (P_2O_5)—not over 0.6 part per million.

While the purification of drinking water is closely related to this subject it will not be considered neither will hardness, gas content nor other related phases.

SEMINAL COLLICULITIS.

BY

HARRY HYZER, M.D., PHILADELPHIA.

Junior Neurologist to Hospitals of the Women's Homœopathic Association.

(Read before the Society of Surgery, Gynecology and Obstetrics, Hahnemann Medical College, Philadelphia, November 3, 1915).

INFLAMMATORY conditions of the verumontanum (variously named) are fraught with such a symptom complex, that a correct diagnosis often presents a difficult problem.

During my association with Dr. Ashcraft for the past four years, it has been my pleasure to observe quite a few cases coming under this category; with this end in view, I wish to present the results of such observations for your consideration this evening.

Unfortunately, the literature on the subject has been quite sparse. This, I believe, has been due in a measure, to the misconception of the earlier anatomists whose descriptions of the verumontanum were rather hazy and inaccurate. The fallacy of these anatomical descriptions has been rendered evident by the advent of the urethroscope, and the observations of Rytina who has demonstrated the actual gross and histologic anatomy of the gland. To quote: "The verumontanum from an embryological standpoint, is developed from the united lower ends of the atrophied Mullerian ducts which explains the origin of its glandular tissue and its homologus relationship with the uterus and vagina. Further, he has differentiated the organ into a central glandular and a peripheral stroma portion, the glandular portion consisting of groups of glands, showing numerous intra-acinous proliferations and these infoldings are composed of several layers of varying types of epithelial cells. The organ at its base is encapsulated with dense bands of fibrous and elastic tissue." Of its pathology, the colliculus may show simple congestion of its mucosa, especially posterior. It may be so distended as to fill up entirely the lumen of the urethra, or as in many cases, well defined, showing multiple cysts and minute ulcerated areas with pus exuding from their openings. In the acute cases the entire prostatic mucosa is in a state of marked hyperemia; while by contrast in the chronic cases, the surrounding tissue is normal in appearance, while the colliculus stands out prominently, hypertrophied, firm and infiltrated.

The etiology of colliculitis may be divided into two types:

the infective and non-infective. In the infective type it has been our observation that the organisms invading the veru and its surrounding tissue of the Neisser variety have their origin in the prostate and seminal vesicles and in other cases the colliculitis was caused by a pyelitis of colon bacillus origin; so that as long as there is vesical infection or infections higher up, treatment directed to the caput per se would be only partially and temporarily successful.

The infective type of colliculitis by far the most interesting as well as the most difficult of treatment owing to the mental condition and chronicity, offers many etiological factors. Most important among which are to be found:

1. Coitus interruptus.
2. Masturbation.
3. Ungratified sexual desire.
4. New growths { hypertrophied stroma. / malformations. / projections.

A history presenting one or more of these factors is sufficient to call for urethroscopy when the diagnosis is apparent.

The symptomatology of colliculitis is quite interesting. Three well-defined avenues (so to speak) lend their aid in the production of symptoms, i. e., the urinary, sexual and the so-called referred symptoms. While in most instances the symptoms are usually confined to one of these avenues, however, it is not uncommon to find the patient complaining of all three.

Of the urinary symptoms: By far the most important is urinary frequency by day and by night, ranging in time from fifteen minutes to two -hour intervals. This is followed by another well defined symptom, that of burning at the termination of urination; in some instances, referred to the head of the penis, others to the perineum. This lasts a few minutes, when the patient has relief in the interval. The urine in these cases is clear, in many instances with mucous floating on the surface. Of course in the *infective* type, it may be clear or cloudy, containing pus, shreds and organisms.

Hæmaturia usually accompanies the acute colliculitis. Likewise in the chronic type where the caput is markedly swollen and congested and kept in this condition by the constant and frequent calls to urinate, hæmaturia is not only demonstrated macroscopically but microscopically as well.

Nocturnal enuresis is sometimes a factor in colliculitis. A case in point was that of a young man eighteen years of age, who came into our clinic at the Women's Hospital whose only complaint was that of nocturnal enuresis since early childhood. There was, however, a history of masturbation. Cystoscopically, the bladder was normal. Catheterized specimen from both kidneys negative. The Buerger cysto urethroscope, however, revealed a swollen, hard, firm caput, which filled almost the entire lumen of the urethra. Colliculectomy was suggested and accepted, with the result that four months later, the patient's mother reported he had not wet the bed since the operation.

The sexual element associated with colliculitis presents a picture which is usually common in not only the non-infective type, but the infective as well, with preference toward the former. Nocturnal emissions are frequent, painful ejaculations, especially referred to the perineum and rectum always followed by marked burning in the prostatic urethra for some hours, and as the patient will often state, "Sexual intercourse makes me worse." This leads to the unfortunate and disturbing mental element, on the part of the patient, that of sexual impotency, which varies from slight impairment to complete loss of function; and, it is just this neurotic element entering into these cases that makes them difficult of treatment.

The so-called referred symptoms are quite important, and in many instances, furnish data which is invaluable. Pain in the lumbar region is quite common, pain that is sharp, severe and occurring at intermittent intervals. Supra pubic distress of a dull, heavy aching character; a distress often referred to the testicle and rectum. Of course, with the above symptoms, one may be led to the erroneous diagnosis of myalgia or neuralgia; but, it has been our experience to go over these cases endoscopically and in most cases the verumontanum is at fault.

Diagnosis. The diagnosis of colliculitis is made upon the clinical history and verified by the urethroscopic findings. It should be borne in mind, however, to differentiate inflammations of the caput from inflammatory conditions at the neck of the bladder, the presence of a well defined prostatic bar, and the entire prostatic urethra. So, in making a urethroscopic examination, not only the veru itself but the entire prostatic urethra, neck of the bladder and trigone, should be carefully examined. Undue sensitiveness and bleeding to instrumentation should arouse suspicion of colliculitis. Where it is necessary to ex-

clude bladder and kidney lesions, it has been our custom to defer urethroscopy until all evidence of cystoscopic examination has worn off. Otherwise, erroneous impressions of the veru per se may be obtained.

Treatment of the verumontanum is entirely dependent upon the etiological factors that enter into the case. In the infective type where the focus is in the prostate and vesicles it is useless to apply topical applications to the caput, even if the urethroscopic picture shows evidence of inflammation. This particular class of cases calls for treatment of the vesicles and prostate by the usual methods of prostatic massage and posterior irrigations, dilatations and failing in these, injections of the vesicles through an opening in the vas on either side (vasostomy). However, in the non-infective type of colliculitis one must exercise due care and precaution owing to the predominant neurotic element present, especially where functional impotency is manifest. In this class of cases, the parts are usually cold and lax to the touch. The general condition of the patient is below par, with headaches and digestive disturbances plus the all-pervading fear of complete loss of sexual virility.

It has been our custom after a thorough examination, to impress upon these patients that they are not hopelessly lost, and ultimate cure is absolutely possible. Insisting upon nutritious diet, exercise, and proper hygiene.

Where there is a tight sphincter ani, divulsion of the same acts wonders. Also, dilatation of the posterior urethra with Kollmann dilator and topical applications to the caput through the urethroscope with varying strengths of silver nitrate 40 to 60 grs., iodine 3 per cent. and copper sulphate 2 per cent.

Unfortunately these cases are usually of long standing have had the usual treatment with practically little or no relief and the urethroscopic picture reveals a hard, firm, fibrotic caput which through repeated cauterization has left a hard, cherry-stone like elevation which defies all effort at alleviation. It is in this particular class of cases that the operation of colliculectomy has been resorted to with marvelous and very gratifying results.

To illustrate:

Case 1.—Mr. W.; age 35 years; telegraph operator; married; mental state was really deplorable. Had been practicing coitus interruptus for five years. Venereal history negative. Consulted for sexual impotency. Urinary findings

negative. Urethroscopically, the caput was well outlined and markedly elevated, swollen, red and congested. Since this patient had been the rounds, so to speak, and informed us that topical applications had no effect, colliculectomy was deemed advisable, not only from the standpoint of the urethroscopic picture, but likewise the psychic effect upon this much distorted mind. To our intense surprise and satisfaction, after giving instruction as to his sexual relations, three months later, patient returned having gained weight and feeling perfectly normal in every respect.

Another case in brief:

Mr. B.; 30 years of age; single; salesman. Complaint, pain in perineum, back and rectum; seminal emissions two or three times a week. Marked frequency of urination. Neisser infection ten years ago; no complications. Cystoscopy, bladder normal. Catheterized specimen from both kidneys normal. Urethroscopy revealed well defined swollen firm caput. Applications of silver nitrate in varying strengths had little or no effect. Colliculectomy was resorted to with the result that two months later, patient reports complete absence of symptoms.

Another interesting case was that of Mr. O.; age 39; single; clerk. Shows all the evidence of the sexual neurasthenic. Loss of sexual power. Nightly emissions at frequent intervals. History of masturbation since early childhood. Venereal history negative. Urinary findings normal. Urethroscopy showed a large, swollen, spongy, bleeding veru, with marked patentcy of the ejaculatory orifices. Instrumentation seemed to increase the congestion and bleeding and the patient became very despondent. Operation was advised and the beneficial results obtained were far more gratifying than anticipated.

These few cases selected at random from a series of twenty-six, serve to illustrate the value of colliculectomy in selected cases. Of course, I do not wish it to be understood that we advise operation in all cases. On the contrary, many of the milder forms of colliculitis clear up nicely with topical applications of silver nitrate. However, in the chronic type, where the caput shows marked elevation,is firm, hard and indurated, and the usual methods of treatment fail, then colliculectomy is the only proper method of procedure, if ultimate success is to be hoped for in the treatment of these conditions.

In conclusion, I am indebted to Dr. Ashcraft for the privilege of his case records, and to his very able suggestions in the preparation of this paper.

ON CERTAIN MECHANICAL CONCEPTIONS OF DISEASE.

BY

BENJAMIN C. WOODBURY, M.D., PORTSMOUTH, N. H.

THERE is at the present time wide spread interest in many forms of mechano-therapy, and likewise a decided materialistic trend in medicine. It was one of the labors of Hahnemann to cleanse the Augean stables of Medicine, and emancipate the healing art from a multitude of unwholesome practices, such as bloodletting, blistering, etc., yet in spite of his Herculean endeavors, there is still much that is left undone. Encumbered as medical practice has been through all these centuries, small wonder that its treatment should be materialistic.

There are certain phases of physical therapeutics to which the popular mind is at once attracted, which can be readily dismissed with the assurance that they are in perfect harmony with natural law, hence should admit of no discussion. By this we would refer to hydrotherapy rightly applied, natural dietetics and hygiene. In the closing sections of his *Organon,* Hahnemann includes a discussion of animal magnetism or what we may now term physical dynamics, which undoubtedly has its own well defined sphere, and it is interesting, in connection with psychotherapy, that the mesmeric movements were always to be "imparted to the patient by the touch of a well disposed person exercising the full strength of his will." Perhaps these careful directions demand more than the secondary importance generally conceded to them. Hahnemann was a skilled physician, yet he was none the less an advocate of preventive measures.

In the consideration of the various schools of mechano-therapy, or physio-therapy, osteopathy must be given first attention. While having experienced rapid growth and achieved astonishing popularity, this method is not without its limitations. Undoubtedly one of the chief criticisms of this system as at present practised is its noticeable tendency to revert to the use of crude drugs and adjuvants. Finding itself unable to cope with a variety of acute disorders, it seeks aid in the use of local treatment, enemata and douches; in fact any

measures which can consistently be recommended to the patient without direct disobedience to the law which prohibits the prescribing of medicines.

Osteopathy as it stands today is a mixture of scientific physical manipulations, and the use of many of the crude, suppressive measures of the regular school. Instead of progressing into osteopathy via homœopathy, its practitioners have entered upon it, by way of the slow and circuitous route of Old Medicine. It is a significant fact that Old Medicine has never yet nor will it ever until it loses its own identity, recognize or investigate homœopathy, or apply it in practice. When such a transformation does take place, it will no longer be allopathy. So it is with many non-medical systems. They are advocates of drugless therapy just so long as their mental or physical measures are effectual. When, however, these fail them, there is but one resort—allopathy.

If osteopathy and other similar systems had been an evolution from homœopathy, rather than an involution of allopathy, it would be worthy of more support and stauncher confidence.

Similarly electricity, if it had been utilized after the method of Hahnemann, might have gained a much more stable place in therapeutics than it now holds.

In the general consideration of physical measures in the treatment of disease, the Hahnemannic method has many claims to priority. We are all more or less familiar with Hahnemann's physical similars: snow to frost bites; hot alcohol to burns, or hot oils such as turpentine, *e. g.,* substances capable of exciting similar burning sensations (not to mention the recent recommendation of gasolene in the treatment of burns and ivy poisoning). We may well add the radiated heat advised by Hering for the cure of snake bite; not forgetting as advised by Hahnemann the relief that is obtained in burns by holding the part *near,* but not *on* the fire. We might also add the rubbing and massage of bruises, which represents the application of a similar measure, applied in a lesser degree. Thus a sharp blow on the shin bone is best treated by vigorous rubbing of the part, until gradually the normal circulation and sensation are restored. So applicable is this treatment, that it is not unhomœopathic to a variety of similar conditions. Thus Hahnemann remarks in his introduction to the *Organon*: "So to give another example from physical action, the injury resulting from a blow on the forehead with a hard substance

(a painful lump) is soon diminished in pain and swelling by pressing on the spot for a considerable time with the ball of the thumb, strongly at first, and then gradually less forcibly, homœopathically, but not by an equally hard blow with an equally hard body, which would increase the evil isopathically."

So universal is this principle of applying friction or pressure, that whole systems have been based upon it, as Swedish massage, the movement cure, spondylotherapy, osteopathy, chiropractic, etc. Unequal pressure brought to bear upon nerve trunks along their pathways and distribution is but another form of traumatic disturbance applied continuously instead of singly, as in the case of a single sharp or sudden blow. No physician doubts the utility of proper mechanical (anatomical) adjustment of purely mechanical lesions. Nor is he uninformed clinically of the wonderfully curative effects of the properly indicated vulnerary. In fact, homœopathy has a whole repertory of anti-traumatics, covering in a very exhaustive manner lesions of bone, muscle, tendon, nerve and brain tissue, all of which are specifically worked out, in accordance with provings and clinical verifications. This does not in any way invalidate the teachings of osteopathy that many mechanical maladjustments are the productive factors in pain, debility, anemia and malnutrition. The osteopath not knowing the extent or sources of the homœopathic estimate, sees in a given case but an osteopathic lesion, whereas it may be a surgical lesion, *e. g.*, one so situated that relief may only be had through surgical measures; or it may be a homœopathic lesion, *i. e.*, one which has its origin in causes which are purely dynamic as certain rheumatic affections, low states of fever, meningeal irritation, purpuric or septicemic states which are productive of symptoms bearing a close analogy to the effects of trauma.

Again, it may be a psychopathic lesion, *i. e.*, one in which no dynamic disturbances are evident. Such a case is no less a form of traumatism and may demand a purely psychotherapeutic regime for its cure, although Hahnemann assures us that most so-called diseases of the mind are in reality bodily diseases. On the other hand some psychical cases do not manifest any well-defined physical symptoms, and such were referred to by him as one-sided cases, which are generally the results of drug poisons or suppression. Both of these conditions are well covered by comprehensive homœopathy.

The appeal that mechano-therapy has made to the layman

and to the non-medically trained mind can but give us pause, that we shall render unto it certain justice that is its due. Any movement which has aided so much in the emancipation of humanity from the abuse of drugs, must carry with it an element of truth. When we consider that there should be some more definite understanding regarding what constitutes an "osteopathic lesion," we are in strict accord with the author of a standard text-book of osteopathy (*The Practice of Osteopathy,* by Chas. H. Murray), who states that:

"Before we can say that a deviation of such a character constitutes a lesion, it ought to produce some pathological condition, or ill feeling of some kind." "It is not every vertebra that is out of line laterally, or deviates anteriorly or posteriorly, that may be said to be out of position in such a manner as to constitute a lesion."

In describing what really constitutes a spinal lesion, he continues:

"There should be some change in color and some temperature near the abnormality. There should be some contraction in the muscles and ligaments. There should be some inflammation, or a congestion bordering on inflammation, near the seat of lesion. There will be pain in nearly all recent lesions. Pain will be present on pressure. In some conditions the muscles in close proximity will be slightly swollen and have a rigid feeling when worked over with the hand. It will be always safe and beneficial to manipulate the spine, ribs, ligaments, muscles, and other tissues, but do not attempt to correct a misplaced bone until it is known to be out of place in such a manner as to cause pressure or is forming an obstruction that is causing some illness. Never manipulate a tubercular joint or spine. Do not cause pressure on lymphatic glands."

"Diseases and disturbances of the circulation are not, as is generally believed by osteopaths, caused by arterial or venous obstruction occasioned by misplaced vetebrae. Vertebral displacements and an obstructed circulation have been the two great points which osteopaths have kept before the public. They have believed this and acting on this belief, in attempting to adjust vertebrae have done much harm to suffering humanity." . . . "The real lesion, or spinal abnormality, when it exists is in a tightened vertebral joint or series of such joints."

Here then is a definite lesion such as any osteopath of experi-

ence should be able to recognize and administer proper and adequate treatment. Such treatment may, however, need to be directed not to the spine at all, but to some remote part, such as the feet, the intestines, the liver or other abdominal or pelvic organ.

As at present practised the name osteopathy is more or less a misnomer for its lesions are referable, not only to the bones as its name suggests, but to the nerves, tendons and soft parts. There should be some more adequate name for the science of mechanical adjustment. Mechano-therapy covers it in a measure, yet this term does not in itself specify just what method of adjustment is signified. Perhaps the future will see all forms of such manipulation under a single more comprehensive name. Spondylotherapy, chiropractic and allied terms are used to indicate special methods of adjustment referable in a large measure to the spine. From its derivation spondylotherapy, which consists in the percussion or tapping of the vertebral spines, might well be called "spinal therapy." Chiropractic methods utilize the so-called "thrust," which aims at the adjustment of the spine or other part by manipulation. Osteopathy, less frequently than in former years, bases its therapy upon the general supposition that bodily diseases are the direct or indirect result of misplacements of the bony structures, producing pressure upon nerves, tendons, and muscular structures, with consequent vascular hyperemia and engorgement.

Etymologically, however, it is interesting to see how far any single term is indicative of the scope of these various methods. Chiropractic which consists in manual adjustment bears the closest relation to the literal definition of surgery, which may be translated "hand-work." Surgery is defined as:

"The branch of the healing art that relates to external injuries, deformities, and other morbid conditions to be remedied directly by manual operations or instrumental appliances."

A more scientific (modern) definition of surgery (chirurgia) is:

"The branch of medicine dealing with diseases requiring operative procedure."

In its broadest meaning, then, surgery or the art of manual operative procedure covers the whole field. May we not see in the near future all such measures recognized by the surgeon and given their proper place in the treatment of the sick? We

believe that here and only here is the proper place for such corrective measures. In a general way orthopedic surgery, which deals with the correction of deformities, should embrace the various forms of mechanical adjustment now so partially and imperfectly applied under the various schools of mechano-therapy.

Whatever virtue may at present be possessed by them, no single one can lay claim to covering so wide a field as that embraced in surgery.

"It follows," continues the writer we have quoted, "that the best treatment will be directed to loosen the tightened joint or joints and so manipulate the surrounding tissues that the circulation will be restored. Chiropractors have been doing their work, using a theory that is entirely wrong, but in practice they have only loosened such joints, and in that way have secured good results. They would secure better results if they paid some attention to surrounding tissues. . . . Spinal vertebrae, of course, are found out of position, but this is seldom a cause of disease, unless such malposition is the result of severe accident. . . . The reader must not think from the above that I undervalue the good results to be obtained in osteopathy, or mechanical treatment, only to obtain better results than have been secured in the past we must perform our work with a view to loosen tight joints, relax muscles, ligaments and fascia and not attempt to move bones that are not causing pathological conditions."

Would it not be better for us, instead of concerning ourselves with structures that have become secondarily involved, except of course in the true osteopathic lesion where the author has stated there is a definite skeletal displacement, to go a step farther and seek the deeper, primary disorders of which twisted vertebrae, splinted muscles, arterial deposits, etc., are the secondary or indirect results? It is undoubtedly true that such primary causative factors are seldom circumscribed within the simple term mechanical lesion, but are more often dynamic and have to do with the organism as a whole. If there are stiffened muscles, contracted tendons and osseous deposits, it is often the result of bad living, improper hygiene, suppression of acute disturbances of the organism, psychical repressions, and inhibitions of the emotions and will. Here is a field which is as yet little explored by the devotee of mechano-therapy. Hence our investigation of this subject must not fail to emphasize

the importance of a return to the study of dietetics, which can be established upon a secure and scientific basis by carefully conducted food experiment, which it is hoped will soon be embraced in the curriculum of every medical school. Such study, coupled with the scientific method of pharmacological research instituted by Hahnemann, will relegate mechanotherapy to the realm of purely mechanical adjustment, which may in the near future lie well within the scope of scientific orthopedics. How faulty and unsafe is any method which treats a mechanical lesion without considering the organism as a structural unit. Thus orthopedic methods for the relief of flat foot have pronounced astonishing results, even in the cure of spinal deformity. Such results will become more striking when it shall have been demonstrated that many lesions of the female pelvis will be quickly alleviated when mankind or rather womankind has emancipated herself from the harmful conventionalities of the corset and high heeled shoe. Again, how multitudinous are the lesions which have their origin solely in deposits produced in osseous, nervous, and arterial tissues, through the injurious residues of devitalized and demineralized foods, the exhaustion and debility that arise in the blood and nervous systems through the false stimulation of irritating spices and condiments, and the depression that follows the excessive ingestion of fermentative and intoxicating substances.

In other words, when humanity will be content to live within natural, normal limits, then and only then will diseases *pari passu* disappear, and not be replaced as at the present time by apparently new and unheard of complaints. Even the followers of osteopathy are coming to recognize that general treatment is often of far greater service than mere local meddling, and this is in strict accord with the teaching of homœopathy. Thus the author quoted, continues:

"In nervous troubles and in many constitutional diseases osteopaths have discovered that they get better results when they give the general treatment. This helps the circulation and makes a tired patient feel like new; and the treatment, after all, when there are no special lesions to remove, is but little more than deep massage, in which nearly all the muscles of the body are manipulated."

In a more recent work, this author has sought to originate a simpler form of treatment under the general term "soma-

pathy," which in its simplest analysis is but the application of deep or subdural massage and hydrotherapy, applied at varying temperatures according to the actual pathological findings; *e. g.,* the application of cold in spinal and general anemia; the application of heat in spasmodic and neuralgic conditions wherever localized. What, finally, is this method but an extension of those very measures indicated by Hahnemann in his consideration of *physical homœopathy,* which is well within the domain or regional modalities and remedial dynamics.

Surely no one will deny that there are times when passive manipulations are not only necessary but beneficial. However, the true therapist sees in them but a roundabout method of accomplishing what nature herself, under the intelligent direction of the will should be able to accomplish for any except those temporarily incapable of self assistance. Hence it follows that, given a little time, the intellect of man will be able to direct our bodies along the lines of self adjustment through proper physical culture, and development, natural methods of eating, drinking and thinking. After all, such a movement will but usher in a new therapeutic order. Such a course could not but seem easy to the follower of vitalism; for the materialist it would be more difficult. The literature of today still deals in a most substantial manner with the mediaeval ideas of plethora, humors, and the *materies morbi* hence its mechanistic philosophy. The followers of Hahnemann recognize the vitalistic or dynamic origin of disease, and see in the localization and statics of disease simply a means for recognizing its deeper dynamics. By this we do not mean to say that disease is not often of purely mechanical or material origin; it is, often: but this occurs in the great majority of cases as a secondary localization.

Homœopathy is the system *par excellence* which recognizes this threefold origin of disease, namely, mental or moral, dynamic and physical. The physical manifestations of disease are to Hahnemann but finalities of dynamic or immaterial origin. Thus we may speak of the physical, the psychological and even of the metaphysical origins of disease. Let us not deny these great truths, but press eagerly forward in our endeavor to eradicate these morbid causes in their smallest and most remote beginnings.

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FIFTY-SECOND SESSION

INTESTINAL OBSTRUCTIONS---MALIGNANT AND MECHANICAL.

BY

G. W. HARTMAN, M.D., HARRISBURG.

VOLUMES have been written upon the subject of intestinal obstruction. Its importance is shown by the large number of articles presented and the merited discussion it receives in medical meetings. Who has not had intestinal cases that baffled his diagnostic acumen and resources of treatment? There is still much to learn about these subjects. I have nothing new to offer this society, but if I draw attention to some points by reviewing a few cases, and thereby emphasize and fix them, the purpose of this paper shall be accomplished. Some peculiar cases of intestinal obstruction came under my observation recently. This fact suggested the topic.

There are two main divisions of obstruction, acute and chronic. The acute type is a serious disease complex, which needs only to be seen to be feared. The chronic is shown by the effects engendered by influences and processes which more or less completely close the intestinal tract to the passage of gases or fæces. These effects do not always make the patient feel or appear seriously ill. I would distinguish between purely mechanical obstruction, mechano-pathological obstruction and symptomatic obstruction, in this consideration. Examples of the first are obstructed and strangulated herniæ, intussusception, volvulus, obstruction due to adhesions, intra-intestinal growths, foreign bodies, etc. Examples of the second are malignant and benign growths plus a foreign body. Examples of the third are found in the numerous and varied abdominal inflammatory conditions that develop along the digestive tract in and about the stomach, the liver and its ducts,

the pancreas, spleen and appendix, the uterus, tubes and ovaries, the kidneys, ureters and bladder.

An unusual case illustrative of mechanical obstruction was operated upon at our hospital by Dr. Bowman, of Harrisburg. The patient, a lady eighty years old, was sent in by Dr. Kilgore. She was a person of unusual ruggedness of health and physique. She reared a family and was spared to them until she had attained the age, four score noted. Her illness started as the result of a fall down stairs. At first it was thought that she was not seriously hurt. She reacted from the shock, but soon began to complain of pain in the abdomen. Her abdomen became distended and tender. Her pulse was rapid and thin, the respirations were shallow, the bowels were locked. A diagnosis of acute bowel obstruction was made, and the patient was prepared for operation. A low median incision, discovered that the parietal peritoneum was adherent to a mass of some kind. The depth of the incision was increased by careful dissection. A cavity containing a lot of cream colored matter of about the consistency of moderately soft butter, was opened into. This material to the amount of several pounds was evacuated. Adhesions were broken up around the enveloping sack which consisted of the degenerated uterus. A hysterectomy was done rapidly, and patient was returned to bed. An examination of the specimen removed showed that it contained more of the mushy material, and also a hard, bony mass of calcified material the size anl somewhat the shape of the parietal bone. The shock of the fall, which evidently changed the vertical position of the calcareous deposit to a position crosswise in the pelvis, and thereby produced the obstruction of the bowel, and the shock of the operation were the factors which contributed to an unfavorable outcome.

A case referred to me by Dr. Bomberger is unique in the findings on the operating table. This patient was in apparent excellent health until it was noticed that she missed her normal daily evacuation of the bowel. She took a laxative without result. She did not feel badly, but referred her case to the physician. He gave evacuants also without results. An osteopath thought he could bring about activity of the bowel and did his worst without avail. A diagnosis of acute bowel obstruction was given, and she was brought in and operated on. At the junction of descending colon and sigmoid, we found a hard mass the diameter of a small sausage, and about 3½

inches long. It felt like a tight intussusception. In attempting to draw it into the field, it fractured through the middle, liberating a round black mass which looked like a gall stone, but which, on closer examination, was found to be a large huckleberry, which had escaped mastication. The lumen of the colon was so completely reduced by the carcinoma of which the growth consisted, that the huckleberry acted as a ball valve and tied things up so completely that not even gas could get by. The growth was removed and the colon was repaired.

I thought these two cases might interest you, because of the peculiar and unusual kind of objects found as causative of the obstruction. However, it is more important to note how grave the pathological conditions were which existed in each case for a long time without producing any discomfort whatever. It is essential to investigate thoroughly every case of intestinal stasis you are called upon to treat, and whenever it seems likely that the bowel is mechanically obstructed, immediate operation is indicated.

The symptoms come earlier in obstruction of the small intestine than in the large, and less time is needed to produce severe lesions in the upper part of the intestinal canal.

In going into a consideration of the third class of cases, I will say that in those the bowel inactivity it is not really an obstruction, but a stasis or paralysis. Appendicitis is familiar to everyone, and you might not look for its consideration in a paper like this because of its more limited scope, but the loss of a case last week has caused me "to take stock," so to speak.

This case, referred by Dr. Swartz, was seen early, diagnosed correctly, operated upon promptly (within twenty-four hours after patient first noticed symptoms) and still was lost. So early, it was a border line case. We found cloudy serum and appendix discolored but not open. It was removed after a difficult dissection, because we did not wish to tear things loose to bring the caecum and appendix up into the wound. The man had a very thick, fat abdominal wall. It was considered safe to close up the incision. Twenty-four hours later he showed signs of deterioration, and in spite of lavage, opening of incision, Fowler's position, Murphy drip and the rest, he died.

I quote E. M. Stanton, who in tracing the processes of appendiceal inflammation and repair finds the following: "There is found a striking similarity in the fundamental pathological

changes as they occur at each of the successive periods following the onset of symptoms. In every case of acute appendicitis on the first there was definite blocking of the lumen of the organ; proximal to this the changes were slight, while distal to the obstruction the lumen was distended to its maximum diameter, there was a deposit of lymph on the peritoneal surface, and at the end of twenty-four hours there was microscopic evidence of gangrene.

"Catarrhal appendicitis was not found as a primary condition and was present only in those cases operated upon during an interval, or in appendices removed incident to some other abdominal operation.

"The peritoneal lesion of the first day is a fibrinous or serofibrinous exudate, and may be ignored from the surgical viewpoint.

"The changes on the second day are characterized by an intense leucocytic infiltration of all coats, accompanied by ulceration of the mucosa, and a well marked fibrinopurulent peritoneal exudate, accompanied by an increase of the areas of gangrene.

"On the third day the process of destruction reaches its maximum, and in the non-malignant cases there are evidences of repair.

"The peritoneal changes on the second day are of two types, either a localized fibrinous peritonitis or a diffuse peritonitis, and it is in the latter cases that appendicitis has its greatest mortality.

"Purgatives greatly aggravate the inflammatory condition, and their administration is followed by perforation and peritonitis. The earlier the peritoneum is put at rest and food and purgatives withheld, the more localized the condition will be.

"In the fourth, fifth, and sixth days in the less severe cases, the repair progresses rapidly, while in the more severe cases there are evidences of the formation of true abscesses cavity formation, but not until the seventh or eighth day are the walls sufficiently strong to permit manipulations incident to packing of the uninvolved intestine preparatory to drainage."

Time will permit no detailed or extensive consideration of my subject, but let me emphasize these points:

Intestinal obstructions; acute and chronic, inflammatory and malignant, deserve much consideration at the hands of both general practitioner and surgical expert.

Second. Diagnosis must be prompt and in surgical conditions, operation must be made early to keep down the death rate. Early operation is easy and comparatively safe.

Third. In late cases more lives are lost by doing too much than by doing too little.

Fourth. Emptying the bowel and draining the intestine are to be attended to even to the sacrificing of speed.

Fifth. The use of laxatives and too frequent use of enemata, may increase rather than relieve intestinal stasis following operation. Frequently gastric lavage with complete rest is all that is required.

DISCUSSION.

DR. SWARTZ: I have nothing to add to what I said this morning about the case. The patient was simply a man who lacked resistance. This lack of resistance manifested itself within twelve hours after a simple operation for an appendiceal condition, which was diagnosed and operated on as quickly as possible. He went down as if he had been shot. The nervous symptoms were simply astonishing. He never reacted, except from the anesthetic, from which he reacted very promptly. He was worked over every minute until he died. It was one of those unfortunate cases that we sometimes meet with. The remarkable thing about the case is that his brother-in-law was operated on ten years ago, and died in two days' time. He was a big, strong man of thirty years. His habits were not so good, however, as in this case. This big, strong young man died of shock. As the doctor says, these things will happen, and you cannot account for them.

DR. VAN LENNEP: I feel *very* strongly in regard to this question. In regard to this case, I do not altogether agree with my old friend, Dr. Swartz. In a great many cases we open the abdomen and find a little serum. In many of these cases we have, perhaps, made a leukocyte count. We find a serous peritonitis and sew the patient up; and he gets a pelvic abscess, and dies of a progressive septic peritonitis. If I should offer a suggestion to my pupil, Dr. Hartman, I would say, in every case in which you have any doubt as to the presence of an abscess or infection, put a drainage tube down to the bottom of the pelvis, attach a syringe, and suck out the fluid; and if you do not get fluid, leave the tube in. Leave the wound open, and a week later make a secondary suture.

I have just run across a case that Dr. Deaver and I worked over. Men engaged in gynecological work take all kinds of liberties with the pelvis, and are inclined to do so with the abdomen, forgetting that when it comes to infections derived from the intestines, we are dealing with a very different proposition. You can do a good deal of work on a pus tube, and the patient will get well; but if you do the same amount of work on the intestine, you get these abdominal infections. When we are in doubt, we should practice self-restraint; and in almost every case in which we have any suspicion we should put a big tube down in the pelvis. You can sew the peritoneum up to the tube and when the tube comes out the wound falls right together.

With regard to the question of lavage I would say that in every abdominal case, the minute the surgeon is through, we wash out the stomach. In a great many cases that we used to talk of as cases of septic peritonitis, the stomach was filled with mucous, bile and gas. These are cases of acute dilatation of the stomach, and if you percuss, you can make out the outline of the stomach and the colon below.

I had a case with Dr. Elliott, in which we employed a little metal bulb with a soft tube. We gave the boy a glass of water to drink, and he swallowed the tube. We passed the tube alongside of his face, and ran the end into a reservoir. He drank all the water he wanted, and it ran out again all the time. This is a continuous washing of the stomach. The tube is very easy to swallow. Its tip looks like a cherry stone. The cost is only about two dollars.

To me, one of the most interesting questions is malignant disease of the small intestine. Dr. Elliott met with two cases, and I with one, of sarcoma of the small intestine. Malignant disease of the large intestine has an interesting natural history. In malignant disease of the caecum, owing to the chain of glands that run from the colon all the way up to the duodenum, you must take out the upper end of the colon and the lower end of the small intestine, and this pyramid of glands all the way up. Where you get the epithelioma type in the rectum you have no metastasis. I have done the artificial anus operation, and the patients have lived for years. The operation of Dr. Willy Meyer is ideal.

OTITIC THROMBOPHLEBITIS.

BY

GEORGE J. ALEXANDER, M.D., PHILADELPHIA.

In a short paper one can only consider the most essential features of the subject of "Otitic Thrombophlebitis," caused by chronic and much more frequently acute suppurative otitis media in two ways; namely, First. By the suppurative middle-ear inflammation, and, second, by metastasis.

Anatomically, the sinuses are venous channels situated between the two layers of the dura mater and form a network that separates the ear from the cerebral cavity; composing this net are, the sigmoid sinus, the transverse sinus, the centrally located cavernous sinus, the superior and inferior petrosal sinuses, and the petrosquamos sinus which is usually absent in adults; continuous with the above are the jugular bulb and the jugular vein which crosses the sternocleidomastoid muscle just behind its anterior border at the middle third which is the most superficial part of the vein, its lower third is under and near the posterior border of the muscle. The vein is separated from the muscle by a thin fascia which includes the carotid artery at about the same depth medianward and the pneumogastric and sympathetic nerves which are deeper seated; the vein being isolated from the artery and nerves by a thick vascular sheath.

The sigmoid sinus and the jugular bulb are in close topical relation with the ear and are in the order mentioned the most frequent seats of thrombophlebitis, even though the distance between the sigmoid sinus and the ear varies greatly, the external signs of which, so far as we know were first demonstrated by Dr. Wieser, of Vienna, and myself.

The blood-pressure in the venus sinuses and jugular vein is low under normal conditions and the current is in the axis of the vessel with but little motion along its walls.

When the inflammatory process spreads from the region of the ear by way of continuity to the sinus, there is set up an inflammatory infiltration and suppuration of the external connective tissue layers (suppurative periphlebitis) which in turn leads to inflammation of the venous wall itself and finally to destruction of the endothelium followed by thrombosis of the sinus contents.

The thrombus may be either partial (parietal) or complete

(obturating), adhering quite firmly to the inflamed parts of the wall and may spread to all the sinuses in the meninges and downward through the jugular bulb involving the jugular vein to any extent even as far as the heart; changes in the parts surrounding the sinuses include pachymeningitis interna and externa, suppurative meningitis, intra and extra-dural abscesses, etc.

The color of the thrombus ranges from dark red to yellowish-green, according to its character; it is seldom sterile, the fresh red thrombus often containing pure cultures of streptococcus pyogenes while the yellowish-green suppurative ones are sterile.

Where the cerebrospinal fluid shows a change from normal there are no doubt, early stages of meningitis, as proved by the circumscribed acute cerebral oedema and hyperaemia of the pia-mater.

It is rather surprising that such a serious affection can be present without symptoms, though earache and headache in the occipital and mastoid regions are usually present and sometimes symptoms of slight irritation of the central nervous system, except in cases where meningitis is already a complication, there is headache, restlessness, nausea and vomiting, numbness, delirium, slow pulse, paralytic manifestations, etc.

The true pyemic form of thrombophlebitis, the one that is generally present is characterized by a temperature curve of the pronounced intermittent febrile type. After the temperature has been normal for several hours, chills will occur, followed by a rapid rise of temperature from normal or below to 102° to 104° or more; the chills vary in number from one at the onset of the sinus affection to several a day for perhaps twenty-five times. There is restlessness, the mind is clear, the patient looks particularly ill and icterus is frequently present, with swelling and tenderness along the posterior edge of the mastoid, and when the jugular vein is involved there may be swelling of the face together with a hard, cord-like induration of the vein on the affected side of the neck, as well as diminished active and passive motion of the head, and in this variety (pyemic) metastases occur in any part of the body.

Another type is that of septicemia, characterized by a continuous fever and symptoms of general infection, it does not occur frequently, and may be associated with the pyemic type.

The presence of an acute otitis media adds difficulty to the diagnosis because of intense symptoms just prior to and during the period of retention of pus, cold feeeling with the continuous type of fever, and oedema over the mastoid may conceal the symptoms of thrombophlebitis particularly because the latter sometimes occurs with a continuous temperature curve, without chills and with mastoid symptoms. I was fortunate enough to see exactly such a case in Alexander's clinic and it added much responsibility and difficulty to the diagnosis. Leutert assumes that a fever continuing several days after subsidence of the acute stage and accompanied by a free discharge of pus from the tympanic cavity, suggests the possibility of thrombophlebitis in acute otitis.

In the absence of serious ear symptoms there is danger of referring chills, intermittent fever and icterus to such other diseases as influenza, gastro-intestinal affections, central pneumonia, etc., without considering the ear as the possible source of the symptoms and assuming that the sinus affections have already run their course thus leading to the danger of waiting before adopting operative procedures on the ear until the favorable time for successful operation has passed.

Again great difficulties may be encountered in incomplete, unreliable, or negative histories, or an afebrile course. A single sign may suggest the presence of thrombophlebitis; for instance, Alexander considers restlessness at night a symptom of sufficient importance upon which to base the diagnosis and I saw him demonstrate its value by finding the thrombus at the operation. It is fortunate too, that in obscure cases the diagnosis can be made at the operation for or indicated in an acute suppurative mastoiditis.

It may be necessary particularly in children to exclude simple otitis media taking an atypical course, malaria, angina, pneumonia, typhoid, otitic descending abscesses and certain initial stages of acute infectious diseases.

As to the differentiation between thrombophlebitis and other intracranial affections the simple cases do not offer any difficulty since the former is characterized by the absence of cerebral symptoms; it should be remembered, however, that all these conditions may co-exist and that meningitis and perforation of a cerebral abscess may set in with chills. The urgency of the case will not permit of observing whether the fever is intermittent or continuous, and from a practical point of view the

only thing to do is to ascertain if there is present an intracranial disease of otitic character to sufficiently indicate operation, at which time there will be no difficulty in recognizing one or more intracranial conditions.

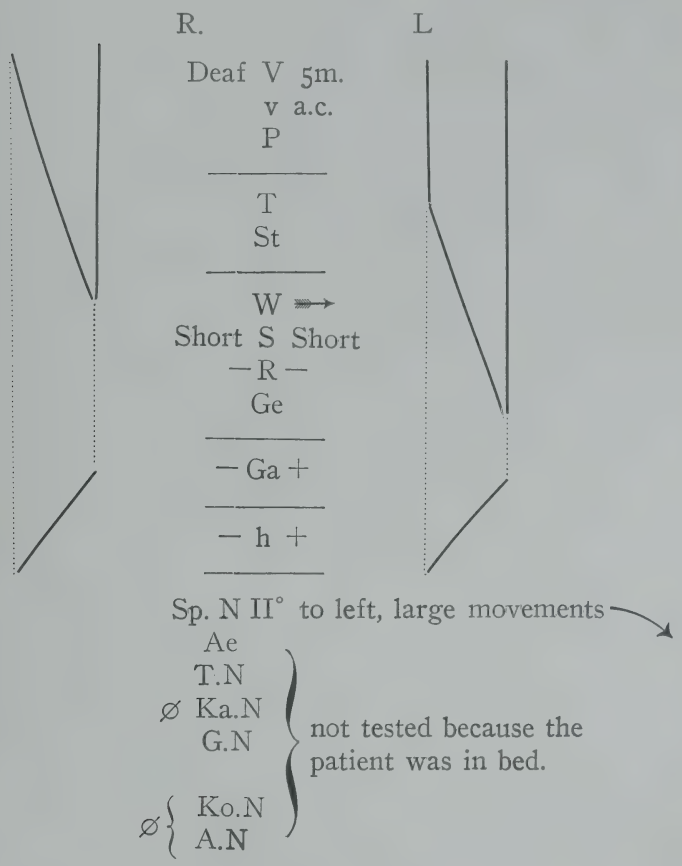
Diffuse labyrinthitis, another condition which may be present as a complication with thrombophlebitis or vice versa, is admirably shown in the following history which I present through the courtesy of Alexander. It pictures clearly the typical symptoms of thrombophlebitis as they become manifest during the already established labyrinthine symptoms.

Male, E. S., age 35 years. Father and mother have been dead for a long time; has one sister living and well. During childhood he had inflammation of the lungs; at the age of six years he was struck on left ear with an open hand, since which time there is impaired hearing in that ear but never a discharge. At the age of fifteen years the right ear began to discharge following an otitis media and has been discharging ever since.

Eight days ago, on arising in the morning, he was seized with a severe attack of dizziness and vomiting, the dizziness lasted two hours; this occurred again the following days but with less intensity and he went to his work every day until four days later when he remained in bed with chills, fever (temperature 102°), headache on the right side, head held toward the affected side, icterus, ideas not clear, reflexes normal, and when he stands, or rises up in bed he becomes dizzy.

Otological Findings.—The right ear showed a foetid secretion, a marked degree of sinking of the posterior superior wall of the external meatus and a bone fistula in the same region. The left ear showed a thin retracted drum membrane with chronic adhesive processes.

The functional tests showed a dead labyrinth on the right side and a high degree of shortened air conduction, considerable shortening of bone conduction of the left ear with spontaneous rotatory nystagamus to the left unaffected side.



The operative procedures were as follows, ligation of the right jugular vein, radical mastoid, labyrinth operation and the sigmoid sinus opened and thrombus removed.

The findings were, cholestatoma in the antrum, a large fistula in the horizontal canal, a profuse discharge of serum from the labyrinth, the sinus wall thickened, green and covered with pus and a thrombus in the sigmoid sinus. There was a discharge of serum from the labyrinth for six days after the operation and the temperature curve was one of pyemia. The patient finally made a good recovery.

Thrombophlebitis is a surgical disease in which spontaneous healing is so rare that it does not deserve serious consideration. Through modern surgery results have been obtained that had not previously been anticipated.

An operation should be carried out in such a way as to pre-

vent if possible sequellæ, some of which are otitic pyemia, suppurative meningitis, thrombosis of the cavernous sinus, brain abscess, quetastasis, bacteremia and toxemia.

The Operation.—In all instances where the operator can feel assured that a thrombus has formed, ligation of the jugular vein is the first step. If the disease is due to acute ear affections antrotomy is performed as the first step, and in chronic cases radical exposure of the middle ear spaces is required; a liberal opening should be made, all diseased tissue removed and the surgeon should not hesitate to remove all the normal bone necessary to trace out the sinus-phlebitis and go well beyond the diseased area of the sinus. In baring the sinus a chisel and a bent Luer's forceps are the safest instruments, the curett should never be used; the sinus wall and dura should be separated from the bone before using the forceps in order to prevent injury as they are closely adherent.

The sinus having been exposed it is noted if its color is a dark blue and if it is pulsating as does the normal sinus, or if it is gray or yellowish-green with no pulsation as when a thrombus is present. The next step is to decide if a thrombus exists, and if it is partial or complete; the best method is to make a puncture 1-2 mm. in length with the scalpel, if the sinus is normal the blood will be expelled rapidly, if a partial thrombus be present it exudes slowly, or in small quantities, in the absence of blood the puncture is elongated and the thrombus is detached from the sinus wall and if by this time there is no blood it is a complete thrombosis.

The presence of a thrombus assured the opening is further enlarged and if partial, a sharp spoon is introduced with its concavity toward the lateral wall of the sinus and the thrombus attached to the wall carefully removed.

In complete thrombosis longitudinal dissection is made upward, the end of the thrombus delivered and the hemorrhage controlled by gentle pressure of an iodoform wick inserted into the sinus, the sinus wall is now divided downward to the lower end of the thrombus to the jugular bulb, the thrombus extracted and the hemorrhage controlled as above, bleeding should be slight if properly managed.

In a partial thrombus the wall of the sinus is left in position and in complete the lateral wall is removed as far as there is any inflammatory process; if the medial wall of the sinus is gray or yellowish-green it means that the phlebitis has spread to this

part and there is present a probable meningo-encephalitis, to decide this a lumbar puncture must be made.

The operation is completed by packing the wound with iodoform gauze and the skin flaps loosely fastened over it; the first dressing is made the first or second day after operation and every day thereafter until far enough improved to require less attention.

Reference: Alexander; Politzer.

DISCUSSION.

Dr. Gilbert J. Palen, Philadelphia: Sinus thrombosis is a very interesting subject. One thing that Dr. Alexander said I have not found in my experience, and that is the occurrence of frequent chills in the daytime, with frequent rises of temperature. I have had a long series of cases of sinus thrombosis, and in my early practice I was disappointed that they did not agree with the textbook description of the condition. Some exhibited not more than one chill, and there were not the frequent rises of temperature that I had been led to expect. It is a rare condition in acute otitis media—not nearly so common as in cases of chronic otorrhœa.

The one point that pleased me most in the paper was the fact that Dr. Alexander brought out the necessity for careful examination of cases of otorrhœa, and that we may have already existing a serious sinus thrombosis with apparently no symptoms; although, if we examine the patients carefully, subjectively and objectively, and make a thorough search for bacteria by means of blood examinations, we frequently discover the presence of these. By eliminating other foci of infection, this gives great aid in the diagnosis. We have had a number of cases in which the diagnosis has been questionable, there being continued temperature and other symptoms in which we have been able to find bacteria in the blood and, by eliminating other foci, to make a diagnosis of sinus thrombosis. Libinau and Zeller have written a great deal upon this subject and have shown that the finding of bacteria in the blood, in cases of otorrhœa, is of marked aid in the diagnosis of sinus thrombosis.

On account of the connection between the cavernous and lateral sinuses, it is possible for a damming up of the current in the lateral sinus to take place to such an extent that the first symptom noticed is a protrusion of the eyeball. I have had such a case, in a patient with obstinate fever for a considerable period. The only objective sign was proptosis, point-

ing to an intracranial lesion. Sometimes cases of sinus thrombosis are treated for typhoid fever. I have seen a number of cases in which that diagnosis was made, and it was only discovered later that the patient had a history of aural discharge. The subject is too deep to take up in a few minutes. It is a condition so liable to arise during the course of chronic otitis media that it is very important. I have been interested in the subject for years, and have tried to impress upon those, with whom I have come in contact, the necessity for a careful examination of all cases during the course of chronic otorrhœa.

A VISIT TO THE MAYO CLINICS, AUGUST, 1915.

BY

H. H. STANSBURY, M.D., BALTIMORE, MD.

In company with Dr. Chas. L. Rumsey of the Surgical Staff of the Hahnemann General Hospital the writer made a visit to the Mecca of American surgeons in the little city of Rochester, Minn., where the force and truth of a prominent author was realized when he said "If a man can preach a better sermon, write a better book or make a better mouse-trap than his neighbor though he build his house in the wood the world will beat a path to his door."

Rochester is a little city with a permanent population of 10,000 inhabitants and a transient population of 300 more, either as patients or visitors to the Mayo Clinics. It is 312 miles west of Chicago and over a hundred miles south of Minneapolis and St. Paul, its nearest large cities.

It is now nearly forty years since Dr. William Mayo father of Drs. William J. and Chas. H. Mayo, whose health had been wrecked with malarial chills in Indiana, determined to leave the malarial section and traveled westward until health was restored and a better climate found. Rochester now stands and marks the end of his pilgrimage, and in my opinion the location of the greatest surgical clinic in the world today.

Here numbers of surgeons make it a rule to visit annually the clinics of Drs. William J. and Charles H. Mayo and their corps of well trained assistants to gather inspiration from the very air of the surroundings as words of wisdom fall from

their fluent though modest lips and their deft fingers do surgery equal to any and surpassed by none. Hundreds of men go to their respective fields better prepared and resolved to do a higher class work the succeeding year.

As soon as we reached Chicago we went to the Great North Western depot and in having our baggage checked to Rochester we were at once asked if we were going to "Visit the Mayos?" by the agent. When we took the train for Rochester the number of invalids and cripples were quite noticeable, as this was their point of destination as was proven next morning.

As visiting physicians the first place to visit was St. Mary's Hospital, here we were requested to register, check our street coats, and put on a freshly laundered short, white coat, provided by the Surgeon's Club. This is attended to by a young lady employed by the Club, who asked if we wished to have our names submitted for membership. She then gave us a printed list of the operations for each of the rooms.

We found sixty visiting surgeons from nearly as many states or foreign countries. I happen to remember now, two surgeons from the U. S. Army, a medical missionary each from China and India. There were men also from Brazil, South Africa, Canada, New York City, Philadelphia, Chicago and Pittsburgh. Operations begin every morning promptly at eight o'clock and continue until the cases are finished, which is usually about one P. M. There are six operating rooms on the top floor of the east wing, well lighted from side and top and large enough to accommodate twenty-five to forty visitors on an iron stage on two sides of the room. These rooms contain all that the average modern operating room does and some that is ultra-modern. For example, all tap water in the operating room is sterile, the surgeon frequently washing his hands at the spigot and going directly back to his work—each of the rooms is provided with a pump operated by being attached to a spigot and used for pumping fluid or pus from cavities, always readily attached at a moment's notice. Two of the rooms have large French plate mirrors immediately over the operating table, tilted at such an angle that visitors may look directly into the field of operation by looking into the glass. The electric bells and signals connected with the operating rooms are worthy of notice. As soon as the specimen is removed by the surgeon the nurse presses a button and a pathologist calls for and makes an immediate report. I have

seen a specimen removed from the operating room, sections made and a microscopical report returned in four minutes. Another push button is used to ring a bell announcing the beginning of an operation—another flashes a light in a ground glass signal box opposite the number of the operating room and the kind of case to be operated. This box can be seen from the doctor's waiting-room or the corridor, as it is set in the wall between. The visitors can thus go from one operating room to another selecting the cases he is most interested in by these signals. I should say the morning's work would average 30 major cases daily except Sunday, in St. Mary's Hospital alone. St. Mary's Hospital has a capacity of 375 beds, always full; with a waiting list while we were there of 250 patients. Patients are gotten out of the hospital in a week or ten days after major operations to one of the many convalescent homes or hotels in the town. The new Colonial Hotel-Sanatorium opened the first of May last with two hundred beds and operating rooms. Here we saw Dr. Henderson, an English surgeon, who is acting as assistant to Dr. Judd of the Mayo Clinic, operate seven cases one afternoon, all of which were chest cases, mostly empyemas. Every bed here is also occupied.

The Kahler Hotel and Cook House, accommodating about two hundred guests each, have operating rooms and depend principally on their support from patients of the Mayo Clinic. The Zumbro Hotel, the best in the city, has no operating room and are not desirous of patients as guests, but even here the influence of the clinics is so much in evidence that the management has placed a sign just outside the dining room which reads: "Please do not discuss operations in the dining room."

THE SURGEON'S CLUB.

Is a permanent organization fostered by the Mayo Clinic, is composed of the visiting physicians in good standing. A temporary fee of $2.00 or a life membership of $5.00 is charged. The Club meets every afternoon at 3 P. M., for the purpose principally of hearing the reporters for each of the operating rooms which had been appointed the previous day by the secretary. He reports each case by giving the principal points in the history and operation and remarks of the operator. The report is then discussed and questions freely asked. In this way a good review is had of the day's work, new ideas

heard and points not clearly understood are likely to be satisfactorily cleared up. The meetings are usually well attended, after which there is a lecture by a member of the staff, a pathological demonstration or an interesting case presented. Once a week the Club is invited to accompany a member of the staff through the Mayo Clinic Building.

THE MAYO CLINIC BUILDING.

In use now for nearly a year, though mechanics were working on some of the laboratories on the fourth floor when we went through last month. It is a five-story building and covers the fourth of an ordinary sized block. The basement is marble and stands well out of the ground, giving ample light on all sides, the super-structure is brick with marble trimmings and cost a half million dollars. It is plainly evident on the inside expense has not been spared on furnishings or equipment.

On the ground floor or basement, is the heating and lighting plant, pharmacy and store rooms. A good portion of this floor is devoted to the bureau of records and statistics, which is carried well nigh the point of systematic perfection. The out-patient clinics and the clinic in orthopedic surgery, serving in the main ambulatory and convalescent cases are provided for on this floor. The general waiting room is on the floor above, with a seating capacity of about two hundred and fifty, and a desk at each of the four corners. At one of these desks a patient gives his symptoms sufficient to be assigned to a department. He is looked over here and is referred to one or more specialists for examination, each of which sends his written results back to the head of the department to which he was at first referred. These examination and consultation rooms are on the first and second floors, arranged on either side of wide corridors which serve as waiting rooms.

A system of colored lights ranged along the corridors announces the presence and whereabouts of each leading clinician. A check upon his presence and location is also kept at a central information bureau, in which he registers upon entry. The bureau clerks, through a system of signals and telephone communications keep touch upon his movements and locate him upon occasion. The registering and communicating devices of the bureau suggest a sort of mechanical detective agency. They give the keynote to the conduct of the clinic: viz., Co-operative Investigation.

The second floor is about equally divided between the clinical service and laboratory research. Here is a series of rooms used for cystoscopic and proctoscopic examination. Last year there were over three thousand examinations made in this department. On this floor there is an entire wing, thirty-four rooms in all, assigned to X-Ray laboratory in which diagnosis and research play the greater part and therapeutic the lesser.

The third floor the purely scientific and literary level of the Clinic is found. It includes the laboratories of histology, pure pathology, physiological and pathological chemistry. These are not laboratories by name only, but are the work-rooms of some of the most distinguished investigators of the United States. Here E. C. Kendal, Ph.D., is engaged solely in the chemistry and analysis of the thyroid gland. He has recently succeeded in isolating in crystalline form a compound containing 60% Iodin from the gland. On the first of last month Dr. E. C. Rosenow formerly of Chicago, a distinguished research worker was made chief of the department of experimental medicine. His recent and valuable contribution in a large series of experiments proves that gastric ulcer can be experimentally produced by the hypodermic injection of certain isolated products of gastric ulcer.

The library of some four thousand volumes and a reading room with not only the leading medical journals of the world but other periodicals of general interest, and an assembly room take up the greater part of this floor.

The fourth floor is given up to the pathological museum, pathological preparation laboratory, photograpic gallery and developing rooms, workshops and repair rooms.

Finally the roof-house crowns the building and crowns it not only in structural but in scientific and esthetic features. Here are to be found a series of animal houses and enclosures, storerooms, and anatomical specimen shop, an X-Ray experiment room, an animal experimentation laboratory—including sterilizing, anæsthetizing, operating and recovery rooms furnish its scientific conveniences. Dressing room, toilet rooms, bath room and lastly a floral conservatory represent its esthetic features.

For years the profession has been visiting this clinic in constantly increasing numbers. It has really been a post-graduate school to many and within the last year, the wealthy University of Minnesota has recognized and decided to utilize this clinic.

The Mayos have offered to spend a million and a half dollars to carry out this project and build a hundred bed hospital for purely experimental medicine—becoming a part of the University of Minnesota. This has been accepted and the plans are well under way, in another decade it is safe to predict that the little path now beaten through the woods to these doors will have become a great highway used by men of all nations on their pilgrimage to one of the world's greatest post-graduate schools of surgery and research.

THE RECOGNITION AND SIGNIFICANCE OF SYMPTOMS AND HISTORY IN THE EARLY DIAGNOSIS OF LUNG TUBERCULOSIS.

BY

BRANTLY F. PARKER, M.D., LANCASTER, PA.

(Presented before the Central Pennsylvania Homœopathic Medical Society, Lancaster, Pa., August 12, 1915).

Mr. President and fellow members of the C. P. H. M. S.: with your kind permission I will read as an introduction a part of Flick's paper on the "Diagnosis of Early Cases of Tuberculosis," as found in Vol. I. Part II., proceedings of Section II., Sixth International Congress on Tuberculosis.

"Tuberculosis is probably always primarily a lymphatic process. As such it canot be diagnosed except by reaction. Occasionally the lymphatic glands manifest the presence of the tubercle bacillus by enlargement. It is possible, however, that when this happens, there is mixed infection and that the enlargement occurs only when mixed infection exists.

"Diagnosis of tuberculosis of the lymphatic tissue, when there is little or no enlargement of the glands, is impracticable. The condition is not a disease in the ordinary sense of that word since it produces no discomfort and no interference with the ordinary pursuits of happiness. Tuberculosis of the lymphatics may produce changes in physiological function and in the form of the body. These changes do not set up disease, however, in the ordinary sense of that term. Underweight relative to height, hypertrophy of the lymphatic tissue in the mucous membranes, bad muscular development and various nervous symptoms, may be due to it, but the relationship between it and the condition is not recognized. Immunity, no doubt, frequently develops in these mild forms of tuberculosis

and recovery takes place without the process having been discovered. These are the recoveries which leave the earmarks found at autopsy upon death from other causes and help to swell the number of implantations of tuberculosis recovered.

"The form of tuberculosis which most concerns the physician is lung tuberculosis. The lungs are most frequently the seat of the tuberculosis process next to the lymphatic system and usually the first in which invasion of parenchymatous tissue occurs. This is because the lungs are most exposed to implantation when tubercle bacilli pass from the lymph into the blood. The lymph which goes into the blood passes through the lungs before it goes into any other part of the body and the lungs are apt to strain out any bacilli which may exist on it.

"The apices of the lungs along their posterior pleural border, probably are the primary seat of lung tuberculosis. Probably both sides are implanted at the same time. But usually one side only has a successful growth for the time being and, as a rule, this is the right side. The growth is usually very small and does not give rise to symptoms which attract attention. This is the real incipient stage of lung tuberculosis, the stage in which it would be most profitable to find the disease. Unfortunately it is not often found in this stage.

"The discovery of tuberculosis in this stage is possible but difficult. The chief obstacle in the way is the general ignorance upon this subject. The people at large have an idea that tuberculosis cannot exist without violent cough, sweat and emaciation, and the medical profession unfortunately still look upon everything short of a fatal condition of the lungs as a mere cold. With the mind preoccupied with erroneous ideas both by the laity and the profession, tuberculosis of the lungs is not looked for until the health is seriously undermined. For the diagnosis of tuberculosis when the process is still limited to the outer border of the lung and the infiltration area is small, the mind must be alert and follow every clue which arouses suspicion. If a person is in ill health at all, if he deviates from the normal in weight, in color, in strength, or in his physical functions, tuberculosis should be looked for. If a history of fruitful exposure to the disease exists, even though the general health is good, it should be looked for. In this connection one should bear in mind that early tuberculosis of the lungs may produce symptoms and may not produce them. If symptoms exist those symptoms

should be followed out until a logical explanation of them has been found. If a history of tuberculosis exists and there are no symptoms, investigations should be made until the existence of the disease can be definitely excluded. In this regard nothing should be taken for granted.

The subjective symptoms in these cases may be an occasional cough, hypersecretion of mucous in the respiratory tract, loss of appetite, a feeling of malaise, especially in the forenoon, flushes, sometimes headache in the afternoon and occasionally a hypersensitiveness of the entire nervous system. There may be alternating vivacity and depression."—Flick.

Before leaving the subject of history and symptoms, I would like to quote from Montgomery's splendid paper, entitled "Differential Diagnosis of Incipient Pulmonary Tuberculosis," found in the same volume as Flick's paper.

"In the diagnosis of incipient tuberculosis, or of incipient disease in general, the history and symptoms may be of paramount value; furnishing at times the only evidence of illness in the patient, so they must be investigated to the fullest extent. Cases of tuberculosis in the family may be overlooked unless the various illnesses and deaths receive detailed and searching inquiry. But while a positive family history is often of value, a negative one is to be disregarded unless very complete and reliable."—Montgomery.

Before enumerating the prominent signs of early lung tuberculosis, allow me to read a few paragraphs from Calmettes' Directory of the Pasteur Institute, a masterly paper delivered at Horticultural Hall, Philadelphia, September 26, 1908.

"Before engaging in battle the generals who direct an army ought to inform themselves as accurately as possible concerning the positions occupied by the enemy whom they are about to attack, his numerical strength, the range of the artillery that he can bring into action and his bases of supply. To obtain this information is the duty of the vanguard and skirmishers. If these branches of the service neglect their duty and permit the enemy to surprise the camp or fortified place, the battle usually ends in the defeat of the defenders. History tells us that beleaguered cities almost always fall into the power of the besiegers."

The same may be said to be true of tuberculous infection. When it has once established itself in a sensitive organism and has begun its ravages, the body finds it very difficult to get the mastery of the invading microbes.

That is why the question of early diagnosis is extremely important in tuberculosis; and since we now know that most tuberculous manifestations, even those which affect the lungs, are more readily cured if they are discovered early, and suitable treatment is adopted. Clinicians as well as investigators should direct their efforts toward increasing the number and effectiveness of the available means of information.

The problem is exceedingly complex because the tuberculous infection remains latent for years, during which time it is compatible with all the appearances of perfect health. The physician's suspicions as well as the patient's, are usually aroused by the sudden appearance of morbid symptoms, which are often exceedingly grave, following frequently some infectious disease, such as influenza, measles, variola, whooping-cough, typhoid fever, mumps or rheumatism. (From my personal observations I would add gonorrhœa and pregnancy), or developing insidiously in the wake of some digestive trouble or other chronic disease, such as diabetes, kidney trouble, cardiac or mental disease, epilepsy, dementia, malignant tumors, and the like. It often happens that nothing has previously occurred to call attention to the initial stage of bacilliary invasion, and in order to discover or even suspect its origin, the history of the case has to be traced back to some remote anterior date. p. 33 "Calmette."

It is not within the scope of this paper to recount the theories of Von Behring or Koch or to dwell upon the investigations or experiments that have been carried on in various countries, nor the astounding communications of the eminent authorities or to dwell on differential diagnosis.

The only reason I have for dwelling so long on history and symptoms as well as quoting the eminent authorities, is the fear that we as homœopaths in our endeavor to prescribe the similimum often fail to recognize many histories and symptoms as so called incipient lung tuberculosis.

In speaking of the early clinical signs, I have taken the privilege of quoting from Calmette, Penzolat, Darenburg, Chirquet, Ott, Holmsen, Landouzy, Barber, Grancher, Hamman, and Berry, ad. lib.

TEMPERATURE.

Among clinical signs that should be sought with greatest attention that which deserves to be mentioned first, is instabil-

ity of the body temperature. The irregularities of temperature observed after alterations of slight fatigue and repose in persons normally fever free, indicates a functional disturbance of the nutrition, which, in the majority of cases is associated with beginning tuberculosis. In general, the thermic equilibrium is disturbed in tuberculous individuals before any other manifestation makes its appearance. An hour's walk is enough to produce an elevation of temperature from four-tenth's to five-tenth's of a degree (centigrade). Dr. John Berry of Pennsylvania State Sanitorium, at Mont Alto, has made extended observations of subnormal temperature as a diagnostic sign, but inasmuch as his observations have not as yet appeared in print, I hesitate to quote him. Observation of temperature at short intervals (every three hours) during several periods of twenty-four hours, day and night, may put the examiner on the track of a suspected diagnosis.

To secure correct readings the thermometer should remain in the patient's mouth a sufficient period—five to ten minutes—and should be taken before and after exertion as well as at frequent intervals.

Bear in mind other sources of slight rise in temperature such as occur in other forms of slight toxemia, infected teeth and gums, diseased tonsils, slight latent infections in the genital tracts of both sexes, fevers of nervous origin and a tuberculous focus located in some portion of the body outside of the lungs. The patient in many cases is not aware of fever though associated symptoms may be present. On the other hand, it is well to recognize that distinctly active tuberculosis may occasionally be present even though fever is totally absent.

Hemoptysis is considered an early sign by Hammer and a great many other writers. A record of hemoptysis even if there has only been streaking of the sputum with blood, and even if the record dates back, should always make one seek to establish a definite cause for its occurrence. Special warning should be given against attributing too readily a small hemorrhage or a slight streaking of the sputum to a simple bronchitis.

The weight: The importance of the weight record in a diagnosis of tuberculosis is taken advantage of by everyone. It is well to know a patient's weight in proportion to his height, his average weight, and the extremes before he became ill and the extremes since his symptoms developed. A general state of subnormal weight is not as significant as an appreciable

loss. A very decided gain under favorable conditions suggests tuberculosis; a failure to gain under proper treatment, the other evidences of toxemia and the physical signs becoming no worse, furnishes some evidence against the diagnosis of tuberculosis.

The sputum: It is a matter of regret that even in these enlightened days we have to reiterate that absence of tubercle bacilli from the sputum, does not indicate freedom from tuberculosis. On the other hand, it should be recognized that the least suspicious looking sputum may contain tubercle bacilli. In doubtful cases the sputum should be examined daily and twenty-four specimens should be used.

The pupils: Dilated pupils indicate some form of toxemia and is almost always found in early tuberculosis. Generally both pupils, but sometimes only one is dilated.

Physical signs: By Grancher's method of delicate auscultation, it is possible to recognize pulmonary tuberculosis in its germinating stage. Instead of attempting to define all the noises which the ear is capable of perceiving,—inspiration, expiration, rales and the like, he confines himself solely and exclusively to auscultating the inspiration and then comparing under the two clavicles and in the supraspinous fossæ, the inspirating sound on both sides of the chest, ignoring all other auscultatory phenomena. The two inspirations should produce on the ear, exactly the same sensations of amplitude and softness characteristic of the vesicular murmur. If there is a perceptible difference, if on one side the sound is more feeble or harsher or interrupted (staccato) there is a lesion at that point.

It is well to remember that feeble, rough, harsh and interrupted breath sounds, are found in early tuberculosis and that bronchi-vesicular respirations in moderately advanced and in advanced cases are also found.

Anæmia: The statement is made by some clinicians that the changes in the inspiratory and expiratory note at the right apex, so often found in young anæmic females, should not be regarded as evidence of a tuberculous lesion at that point. I believe it to be misleading as it seems more reasonable that the tubercular invasion causes the anæmia rather than that anæmia causes the change in the normal breath sounds found in this area.

GLYCOSURIA IN PREGNANCY.

BY

CHAS. M. BROOKS, M.D., PHILADELPHIA.

SOME time ago I had two cases of confinement in which both children were still born though perfectly formed and very large children. As I could not account for their death I began an investigation and found that both mothers were diabetics. The examination of a scanty literature upon the subject shows that two varieties of sugar may be found in our clinical urinalysis,—lactose and glucose. And so we may find one of two conditions present, lactosuria and glycosuria. On account of the vast difference that the differentiation of those sugars make in our diagnoses and prognoses, each is best examined separately.

Lactosuria—Lactose or milk sugar is present in the urine of a small percentage of cases just prior to parturition and of a large number at some time during the few hours or days immediately following delivery. It is also present occasionally just after the mother has weaned the child. In other words lactosuria may be present at any time when the breasts are functionally active and the escape of the product of that activity, milk, is impeded in any way. The condition is one of absorption, and so while lactose cannot be said to be a normal urinary constituent certainly it is not pathologic. So common may be this lactosuria that some have gone so far as to suggest urinary examination of professional wet nurses in whom the presence of lactose might be regarded as an indication of healthy mammary activity.

May demonstrated lactose in seventy-seven percent of his cases; McGann and Turner in one hundred percent; Williams in twenty-six percent and Payer in four percent. Dorlan claims it to be present in about twenty-five percent, while by Fehling's test Hirit found it in less than one percent. The great discrepancy in the results of these investigations is probably due to one of two things. The lactosuria is very often of short duration, being present at one examination and absent at the next and perhaps present at some later time. Or it may be due to the inadequate tests often used. Some of the reagents used for the detection of glucose being quite useless

when dealing with lactose. Without doubt, if urinary examinations were more frequently made by obstetricians immediately before and after labor, sugar would be more frequently found. Under ordinary circumstances, tests for albumin, examinations for casts and probable determination of urea, make the limit of investigation, and then possibly a month before delivery. Yet it must be remembered that lactose acts differently on many media than does glucose. Copper salts in alkaline solution are reduced by lactose after boiling, but much more slowly than by glucose. And so the Fehling, Frommer and Haines tests react but slowly. Small traces of lactose may be easily overlooked when performing these tests. Lactose does not ferment with yeast, in this way differing widely from glucose. It responds but incompletely to the phenol-hydrazin test. Therefore, when we have a specimen of urine that does not ferment with yeast, responds to the alkaline copper solutions slowly and deflects polarized light strongly to the right, lactose is probably present. The reason for this lactosuria probably lies in the fact that lactose in the blood is not assimilable. When introduced into the alimentary canal it is perfectly assimilable, undergoing no change in the canal itself, but being transformed during absorption by the intestinal walls. When experimentally placed in the blood stream it soon appears in the urine unchanged. Lactosuria in the pregnant or parturient woman then, is an abnormal but not a pathologic condition. As such it requires no treatment. Many cases illustrating lactosuria might be cited, one, a patient with whom the writer has come into contact and one by Dr. Harberon. The first is a case of primipara who passed an apparently normal pregnancy, was delivered of a healthy child and is at present in a normal condition. In this case a small amount of sugar appeared in the urine for weeks prior to delivery, gradually increased in amount until about three weeks before confinement, it amounted to about one-half an ounce in the twenty-four hours. From this time a slow but steady decrease was noticeable, all traces disappearing soon after delivery and never reappearing. Both mother and child made a good recovery and at present are perfectly healthy. The case of Dr. Harberon was as follows: A young lady, Mrs. F., who in two previous lactations had a very copious supply of milk and had at weaning very distended and painful breasts requiring medical treatment, wished to wean her eleven months' old child,

although the flow of milk was still copious. When the suckling was stopped the breast became as before, very distended and painful, and the treatment of belladonna, painting and firm bandaging were resorted to. At this stage she came under his notice with three percent of sugar in the urine (13 gr. to 1 oz.), the specific gravity being 1039. Under the usual treatment, in four days the breasts were much improved, softer and not so tender and the urine contained a trace of sugar only, the specific gravity being 1026. Four days later the breasts were normal in consistence and size, the tenderness had disappeared and the urine was free from sugar, with specific gravity 1021. Now, the sugar fall corresponded exactly with the stages of recovery of the breast trouble and it is scarcely likely that the production of sugar in the liver would be so finely adjusted in sympathy with the breast changes as to drop from a larger production to none in the short space of eight days. The breasts were distended with milk and firmly bandaged so that the same condition held as in a knee distended with synosidal fluid which has been bandaged firmly to cause absorption of the fluid. Absorption does occur in the knee, why not in the breasts in the same conditions?

I may be pardoned for adding a word of advice which may be of use to some. If sugar be found in the urine of pregnant or suckling women look to the state of her breasts before diagnosing "diabetes." Often transient cases of glycosuria are diagnosed "diabetes" for want of sufficient care in investigation.

Glycosuria, quite different from this physiological state is the condition when a true glycosuria is encountered. On account of the important nutritive changes taking place during gestation, and the facts that all parts of the body are being affected by them, it is not surprising to find certain functional disorders in organs other than those directly connected with the uterus. Payer claims that women are less tolerant of sugar during pregnancy than at any other time. He was able to produce a temporary ailmentary glycosuria in eighty percent of his cases by increasing the amount of sugar ingested.

This brings us to a consideration of a much less common but by far more serious complication of pregnancy, namely true diabetes. Several things combine to make this complication an unusual one. In the first place, diabetes is less common in women than in men. The ratio being about two women to

three men. It is a disease of adult life, more particularly of advanced adult life usually appearing at or after the climacteric has been reached and so, of course, too late to connect it with pregnancy. This demonstrates that of the entire number of diabetics, only a small proportion will be at the stage of generative activity and capable of bearing children. And the probability of this complication is still further lessened when it is remembered that diabetes not only has a debilitating constitutional effect, but acts directly upon the centers controlling the sexual functions, including sexual impotence. It further predisposes to local inflammatory changes within the uterus, dysmenorrhœa, menorrhagia, and amenorrhœa. All of these things when combined with the many cases that have never been recorded, even if they have been recognized, bring our list down to very small proportions, so small as to be of questionable value as a source from which to draw conclusions. Pregnancy may occur in a true diabetic patient or diabetes may develop in pregnancy and continue after delivery, or may subside and recur in later pregnancies, puerperal diabetes. This latter may be present once, and skip the next or several following confinements and reappear in some later one. Of these two classes of cases twenty-eight instances have been reported in medical literature the results of which have been tabulated by Puoff, some of whose statistics are quoted:

No. of cases reported	28
No. of pregnancies	66
No. of labor at term	42
No. of miscarriages and premature	24
No. of mothers living	15
No. of mothers dead	13
No. of children living	31
No. of children dead	35
Percentage of mortality mothers	46
Percentage of mortality children	53

When we realize that future results follow for nearly one-half of the mothers and far more than one-half of the children, the severity of the combination is evident. So severe does Fry consider it that he has stated that "diabetics" should not marry. While this is a more stringent rule than many other obstetricians follow, it seems at times to be the best course

to pursue. As has been seen the chances for a diabetic to become pregnant are few, but if this does take place the prognosis is certainly grave. When pregnancy is present in true diabetics, are we justified in interfering with its progress? A glance at the foregoing table shows that in over sixty-five percent of the cases reported, labor has taken place at full term and in a normal manner although often the child was dead. There is at present insufficient literature to justify such a course. If, however, all the symptoms fail to respond to treatment and increase in severity, then may such interruption be conceded? Death of the mother occurs from coma or collapse, never from eclamptic attacks. Such a termination in other diabetics is frequently brought on by some severe exertion. So in pregnancy, it is probably not the pregnant condition itself that brings on the end, but that the physical exertion and shock incident to parturition is the direct cause. The conclusions may be reached as follows:

I. The variety of sugar present should always be determined in pregnant cases.
II. Lactosuria is not pathologic and so requires no treatment.
III. Small amounts of glucose may occasionally be present, as an alimentary glycosuria and without significance.
IV. Diabetes may be caused by the pregnant condition and so be a cause of fatal results.
V. True diabetics seldom become pregnant.
VI. Mortality for both mother and child is very high.

Fibromatosis of the Mamma.—Lexen (Munich) found fibromatosis in four cases, which clinically appeared maligant, and were radically operated. The case presented pain in the breast, hardness, adherent tumor and enlarged glands. The patients were at the age suggesting cancer. The tumors had no capsule, had grown into their surrounding tissues and on section have a reddish grey color. Histologically the connective tissue was increased and sclerosed, with hypertrophy of the contained glands and cyst formation from compression of the efferent ducts.—*Abstr. Zentralbl f. Gyn.* 1914—1407.

EDITORIAL

MEDICAL PRESCRIBING IN HOMŒOPATHIC HOSPITALS.

It has been the custom among a certain class of homœopathic physicians to criticize the prescribing in homœopathic hospitals as falling short of what might be reasonably expected in institutions founded and maintained for the purpose of giving the public the advantage of the homœopathic method of treatment. We do not doubt but that a certain amount of the criticism along this line is justified and that it has a beneficial effect in preventing hospital physicians from falling into a slipshod method of therapeutics which entails less mental effort than finding the indicated similar remedy. We have long been satisfied however that this criticism has been carried to an unjust point and that in the majority of homœopathic hospitals at least, the medical treatment approaches much more closely the true ideals of our school than is commonly found among the rank and file of homœopathic practitioners. In connection with this subject we have been much interested in the statistics collected by Dr. O. S. Rich of Brooklyn, and presented before the American Institute of Homœopathy at the Chicago meeting. Dr. Rich has gone very carefully over the prescriptions made in the wards and in the dispensary connected with the Cumberland Street Homœopathic Hospital of Brooklyn. He finds that out of 26,264 prescriptions recorded in the hospital wards for a period of one year beginning May, 1913, 24,358 or 86½ percent were homœopathic, and 1906, or 13¾ percent were non-homœopathic. In the dispensary, out of 16,143 prescriptions, 13,353 or 79 1/6 percent were homœopathic and 2970 or 20 5/6 percent were non-homœopathic. We do not find the statistics of other homœopathic hospitals available at this time, but, being associated in an official capacity with a number of homœopathic institutions we are satisfied that the statistics of the Cumberland Homœopathic Hospital represents a fair average of our up-to-date institutions. Leaving out of consideration however other institutions, we should feel that the statistics of the Cumberland Street Hospital would be suf-

ficient to satisfy the most enthusiastic advocate of homœopathy and of the character of prescribing done in this institution.

It is, of course, conceded by every physician who has made a study of the claims of Hahnemann and of the philosophy of homœopathy, that the homœopathic principle of prescribing is limited to the selection of the remedies acting upon the dynamic or vital functions of the body cells. It has nothing to do with antiseptics, with paraciticides or with the purely chemical or mechanical action of drugs. The use of a purgative such as Epsom Salts is certainly not homœopathic; neither is the employment of such a substance for the purpose of securing an evacuation of the bowels contrary to the law of similars. It is a sphere of drug action entirely distinct and apart from the action of a curative homœopathic remedy and bears no relation to it whatever. The wisdom or folly of making use of the action of purgative remedies in the treatment of disease conditions is a mooted question which must be settled upon other grounds than those which concern the action of a homœopathic remedy. In the same way it must be said that the use of opium or morphine to relieve pain, a purely palliative procedure, which is never curative in its effects, is a matter entirely outside the sphere of homœopathic prescribing and has no more bearing upon the law of similars than the law of gravity has upon a ray of light. When we consider, therefore, that homœopathy can appropriately claim to deal only with that sphere of medical therapeutics which has to do with the selection of remedies for the purpose of bringing about a curative action through stimulation of the activities of the cells of the body and that there must arise in practical work, conditions where chemical, mechanical or palliative action of drugs must be employed by the physician who desires to act for the best interest of the patient, we consider it quite remarkable that a hospital with such a large service as the Cumberland Street Hospital at Brooklyn should show in its reports such a large percentage of strictly homœopathic prescriptions. We are convinced that a great deal of the criticism directed against homœopathic hospitals along this line, is unjust and that in the main the prescribing in our medical institutions fully measures up to what may be expected of a practical homœopathic prescriber who is acting for the best interests of the patients under his care.

G. H. W.

TETANUS.

The large number of cases of tetanus developing as the result of wounds in the European War has served to draw the attention of medical men to this disease and has furnished opportunities for a complete study of the disease and of the effective means of combating it from the therapeutic standpoint. It has been known for a long time that wounds contaminated with soil containing excreta of household animals are most likely to develop tetanus. The organism is constantly present in the dirt of the cities and roads as well as in barn yards and pastures. Wounds that are associated with bruising or crushing of the tissues are especially favorable to the development of tetanus bacillus. The period of incubation is from one to ten days and it has been found that about fifty percent of the cases develop about the sixth or seventh day after infection. The organisms are not often carried far from the point of infection and produce the symptoms entirely by the production of a toxin which ascends the motor nerve sheaths and then reaches the spinal cord. The toxin of tetanus enters into a firm chemical combination with the nerve cells causing irritation resulting in spasmodic contractions of the muscles which are accompanied by considerable pain. From this fact it is evident that it is more difficult to combat the disease by antitoxin when the disease is fully developed. Recent discoveries, however, have given us a method of employing antitoxin in a way that not infrequently saves human life even after the symptoms have all appeared.

The prophylactic treatment of tetanus consists of thorough cleansing of the wound together with the removal of all crushed and devitalized tissues about the wound. Following this fifteen hundred units of tetanus antitoxin should be injected subcutaneously, preferably in or about the region of the injury. This dose should be repeated in a few days if it seems probable that tetanus infection has occurred. When the patient comes under observation after the muscular spasms have developed, active treatment is necessary in order to save life. From three to five thousand units of antitoxin should be injected into the lumbar region of the spinal canal and ten thousand units should be given intravenously. Both the intravenous and the intraspinous injections may be repeated in from twenty-four to forty-eight hours. It is usually advisable to make the intra-

spinous injection under an anæsthetic in order to prevent the possibility of a convulsion during the injection.

A number of severe cases of tetanus have been saved by this treatment and we are convinced of its practical value from personal observation in the cases recently brought to our notice. The treatment by chloral, carbolic acid, magnesium sulphate and a variety of other measures that have been suggested from time to time have proved practically useless in military experience abroad. It would seem that both as a preventive measure and as a curative agent during the fully developed stage of the disease, tetanus antitoxin is by far our most effective therapeutic agent. G. H. W.

STATE SOCIETY DEPARTMENT.

RALPH BERNSTEIN, M.D., EDITOR.

A Communication to Members of the Homœopathic Medical Society of the State of Pennsylvania:

It is almost universally conceded by the dominant school of medicine that the application of drugs is abused and they even question the usefulness of medicinal therapeutics, but the most eminent men believe in what they call the modern treatment of disease where they rely on so-called natural methods.

Helping nature to do its work in a natural way, is, indeed, commendable and should be encouraged to the highest degree, but too often the natural forces are sidetracked into an open switch on a downward grade and it takes something more than the natural forces to get them back on the main track to enjoy the comforts of the Pullman. To get them back you must still stick to natural laws to guide you in your method and save as much of the wreckage as possible.

Just think of the extreme violence that used to be in force, the strongest remedies, bleeding and blistering, vomiting and purging in typhoid fever. Now they give baths, careful nursing, etc., but rarely give medicine at all. In the Paris and Vienna schools, drugs have shaken the stoutest faiths, and partly on account of the constant and reproachful object lessons of homœopathy. No regular physician would ever admit

that the Homœopathic infinitesimals could do any good as a direct curative agent, and yet it was certain that homœopathists lost no more of their patients than others. There was but one conclusion to draw, namely, that most drugs had no effect whatever on the disease for which they were administered. The quotation comes from no less an authority than Osler.

They acknowledged at least that we get equal results, and if that is true, why not stick to the simple remedy and devote our time and energies to prove the superiority of our law. This behooves us to perfect more perfect organizations in the counties, states and nation. Are we all willing to do our share in the work? United efforts win most anything and is bound to advance homœopathy so it will leave its footprints on the sands of time for ages to come. Are you affiliated with your local and State Society?

Think it all over brother practitioner and see wherein your duty lies to help in this great work. If you are already a member of our societies, ask your nearest neighbor whether he is, and if not get him to join. I would like to have a personal interview with each member of the State Society and ask him for his co-operation in the work of securing new members. If you think the society is not what it should be, come along anyway and help to make it better. To find fault a man must have ideals and ideals are what we are looking for and we cannot come up to your standard unless you tell us about them.

J. M. Heimbach, M.D., *President.*

Chronic Cystitis.—Smith (Boston) says chronic cystitis in women is never a disease by itself, but is only a symptom of infection higher up or of a general disease. In eighty-seven cases he found non-tubercular renal infection in 61 per cent., renal tuberculosis in 10 per cent; insufficient emptying of the bladder 7 per cent., infection of the ureter or renal pelvis 7 per cent.: other cases 6 per cent. In every case the urologist should determine the real disease to which chronic cystitis is secondary.—*Abstr. Zentralbl. f. Gyn.* 1914—498.

Pott's Disease.—Undoubtedly surgical measures in Pott's disease shorten the period of disability with a presumption of a rapid cure. But rapid cure, in the exact sense, cannot be obtained by any method of treatment in tuberculous spine disease. In comparison to conservative methods, bone transplantation followed by protective treatment shortens the duration of tuberculous spine disease many months. The early relief afforded patients from discomfort and pain following the operation is striking.—Charles M. Jacors in *The J. A. M. A.*

GLEANINGS

Some Points on the Administration of Thyroid Extract.—Until quite recently the generally recommended dosage of thyroid extract was altogether too large, at least, in the majority of cases in which it is to be given. This was doubtless due to the fact that the original dosage as indicated in the various pharmacopeias was based upon experience with this extract in the treatment of athyroidic individuals. It is true that a commonly suggested dose—five grains three or four times a day—is none too much in the major thyroid deficiencies, cretinism and myxedema. Occasionally it may be even larger; but since thyroid is used very frequently in a host of other conditions of functional minor hypothyroidism, it is well to remember that the dose in such cases is very much smaller: 1-10 to ¼ grain given three times a day usually suffices.

Small doses of iodine, 1-50 to 1-100 grain given conjointly with thyroid extract frequently make the therapeutic reaction more decided and Osborne, of Yale, has called attention to the fact that seemingly inert thyroid preparations regain their activity when iodine is added. Potassium iodide in small doses also has been suggested as a useful adjuvant to thyroid therapy.

The variation in thyroid products of different manufacturers is quite an important factor. Many articles have been written regarding the importance of the iodine content, and the differences between extracts made from glands taken from sheep of different ages and at different times of the year. In the writer's opinion, the location in which the flocks of sheep have grazed has a great deal to do with the activity of the extracts made from their thyroids, and by far the best preparations are obtained from the organs taken from young sheep which have been pastured near the sea—iodine, it will be remembered is distinctly a seaside product.

Occasionally patients need thyroid extract, but do not seem to tolerate it well. In such cases the whole day's dose, ½ to 1 grain, may be given just before retiring thus obviating some of the inconveniences with the heart and respiration. In these cases Heinrich Stern suggests that arsenic —sodium cacodylate—in small doses may be given conjointly with thyroid to prevent the untoward symptoms.

The indications of thyroid overdosage are obviously an admonition to stop the dosage temporarily. The principal manifestations are increased heart action and perhaps a slight rise of temperature, as well as headache, nausea, irritability, restlessness and occasional pains in the limbs and back.

French authorities recommend the use of one centigram of thyroid extract (1½ grains) to be given daily in a single dose, but more frequently in divided doses, for one week. The medication is then omitted for a week or even longer, and begun again. Occasionally individuals super-

sensitive to thyroid medication may establish a tolerance to a given dose and after reducing the amount and starting it again, it may be found that they are able to take very much larger doses without any of the previous symptoms of intolerance.

In women, especially those suffering from obesity, who are taking thyroid to facilitate reduction it may be that the addition of corpus luteum to thyroid, say ½ grain of thyroid and 5 grains of corpus luteum three or four times a day will bring about much better results than the thyroid alone. This is particularly true in patients near the menopause.

The use of thyroid extract for children—it is one of the most commonly used organotherapeutic agents in pediatric practice—must be regulated very carefully and unlike alkaloids and mineral drugs, the dosage does not depend upon the body weight or age, of the child, but rather upon its individual susceptibility. The only way to establish proper doses is to give very small doses—1-20 grain—to start with, gradually increasing the amount until a maximum is reached, watching very carefully for the first evidences of intolerance already mentioned.

Under no consideration should thyroid be permitted to be used indiscriminately and without the most careful medical supervision.—*Amer. Medicine.*

Arteriosclerosis as a Cellular Disease.—Bishop in the *New York Medical Journal* gives a summary of his views of this omnipresent condition. By arteriosclerosis I mean the general disease with which every physician is familiar, but which is very badly named when it is called arteriosclerosis. Like many other conditions it has received its name from a localized condition, just as enteric fever is a synonym for a certain disease that consists of a bacterial invasion of the body by certain specific germs that get into the blood stream, pervade all the organs, and run through a certain cycle of events leading normally to the production of the necessary antitoxins and the recovery of the patient. Enteric fever is a very inadequate name, and was given to the disease because in most cases—if not all—there was an ulceration of the intestinal tract which was seized upon as the supposed seat of the disease, and gave the name to the condition.

In the same way arteriosclerosis, a general disease, from which no part of the body is exempt, involving in a degree all the organs of the body, has received its name because in its well developed stage the arteries are found—when they are observed—to be thickened and conspicuous. Like typhoid fever, arteriosclerosis is a general disease. It is not due to a particular microorganism. It is due to what is known in medicine as a "disturbance of metabolism." The term, disturbance of metabolism, means very little unless we define it.

In this instance, we define it as the processes of the ultimate products of digestion to the nourishment and maintenance of the cells of the body. That is metabolism.

A disturbance of metabolism is a disturbance of the relation of the ultimate products of digestion to the nourishment and maintenance of the life of the cell.

So the disease, arteriosclerosis, is a disturbance of the relation of

certain material which comes from the food for the maintenance, nourishment, life, and health of the cells of the body. As it involves all cells of the body, it is liable to be more pronounced first in one place and then in another. You all know what a person with advanced arteriosclerosis looks like.

Any one with this condition might also be defined as suffering from cardiovascular renal disease. You know that when such a person comes under observation in a well developed stage of the disease, you are puzzled to know whether you are dealing with a heart condition, whether you are dealing with a kidney condition, or whether you are dealing purely with a bloodvessel condition. You know that the functions of the intestines, liver, and kidneys are involved, and you know that whatever conclusion you reach, someone else will say to the contrary: If you say the person suffers from heart disease, somebody else will say he is suffering from kidney disease; if you say kidney, somebody else will say arterial disease. So it is not possible in these conditions to say just what the nature of the disease is, provided that you insist upon the organic nature of the disease.

This problem is so interesting that it has occupied much of my attention, and I have reached the conclusion that the condition known as arteriosclerosis is really a disease of the cells of the body, and that the involvement of particular organs is a matter of sequence and follows on the general condition.

The cell must digest its nutrient material or else it cannot be nourished, just as the animal must digest its food before it can become available for the nourishment of the cells. Thus we have two digestions: One which is very conspicuous, the digestion of food by the gastrointestinal tract, which is interesting to everybody and is a matter of consciousness. It is only relatively important compared with the other digestion. The other digestion consists of the digestion of food by the individual cell, and that digestion is of vast importance and extremely complicated. The gastrointestinal digestion consists simply in the preparation of food for absorption —of the breaking down of food into the simpler forms so that it may be easily absorbed into the blood stream. The food is not much changed by gastrointestinal digestion. It is rather torn apart into its fundamental divisions. The animal food is broken up into its aminoacids and so forth, but the aminoacids are not broken up and their nature is not changed by the gastrointestinal digestion.

Metabolism is entirely different. In the process of metabolism, the protein molecule is absolutely broken up and its identity is completely lost. That is a very complicated biochemical process and is carried on by a great many organs. It is carried on by the liver, the spleen, the thyroid gland, the suprarenal glands, and kidneys, which have all some metabolic function. The marrow of the bones and the ductless glands have to do with the process of metabolism. Many chemical processes are carried on in the muscles.

As I say, this digestion is vastly more complicated and vastly more important than the gastroenteric digestion because unless metabolism is well carried on, the body is not well nourished and is diseased as a whole.

The question arises then, Why is it that a healthy man develops this

condition which gradually irritates and destroys the cells of the body and leads to the production of connective tissue?

The answer is, that it is because of the disturbance of metabolism.

The nature of this disturbance of metabolism is very obscure, and the hypothesis that I have elaborated is that it is due to a disturbance of the relation of particular proteins to the body cells. In other words, the cells of the body become sensitized to particular proteins.

If you take a guineapig and inject into its blood a small amount of egg albumen, which is a simple form of protein, the pig becomes sensitized to white of egg. If later, you give the pig more white of egg, all the cells react in a manner known as anaphylaxis, and very often the guineapig dies. That is a simple laboratory example of sensitization.

If human beings become sensitized to proteins, which seems to happen from nervous shock, acute food poisoning, some infectious disease, or something else that makes a profound impression on the organism, from that time on the cells of that person's body may be unable to deal with the particular protein in question. Bacteria from a form of suppuration may provide the offending protein.

We do not have to go very far to find examples of food sensitiveness. You all know people who cannot eat fish, strawberries, or this or that kind of food, and are made sick by them.

I saw a gentleman this morning who one Easter when he was a boy, gorged himself with eggs. He ate a great many eggs—I don't know how many—and was made very ill, so that he had nausea, vomiting, and fever. He was confined to his bed and made a slow recovery. It was a case of acute food poisoning, from eating a great number of eggs. Following that, every few days he would be sick again. Finally it was discovered that if he ate eggs it made him absolutely ill. He stopped eating eggs or anything with eggs and got on well. For thirty years the man could not eat eggs or any article of food with eggs in it because that poisoning had caused him to be sensitive to eggs.

I know a doctor's child who is so sensitive to fish that if you conceal a piece of fish in a potato, and the child eats it, he is sick before he leaves the table. We can parallel such examples numberless times. I have heard of a child who was so sensitive to eggs that his eyes would water if eggs were opened in the same room.

Unfortunately—I say unfortunately because I mean it—food poisoning is not by any means always accompanied by disagreeable symptoms. In fact, food poisoning may be accompanied by agreeable symptoms, just like any other poisoning. If a person is slowly poisoned by arsenic, it gives him a sense of well being until it is withdrawn. The same is true of other poisons. If a person is poisoned by meat, the withdrawal of meat is accompanied by a sense of prostration, and the restoration of the meat by stimulation. If the person is not poisoned by the meat, it can be withdrawn without any particular discomfort.

The natural history of the production of arteriosclerosis is, I believe, as follows: The person goes through a period of great nervous shock or strain, some very acute illness, or some acute food poisoning, and this produces a change in the relation of the body cells to the customary food proteins. The person may be sensitized to meat, fish, eggs, or other pro-

teins. When a person has been sensitized to food protein and goes on eating that food, the cells of the body are irritated and some of them destroyed, and the organs become defective and are not able to do their work properly. When the kidneys become markedly sclerotic they do not function normally and Nature attempts to make them function better by a rise of blood pressure. This rise of blood pressure leads to hypertrophy of the heart. It leads to thickening of the bloodvessels and that creates a vicious circle. The high blood pressure damages the bloodvessels and the kidneys are further and further damaged until finally we get the picture of cardiovascular renal disease.

Such a person coming under medical observation is ordinarily said to be suffering from one or other of several conditions—either heart disease, bloodvessel disease, or kidney disease. In reality, it is all one thing. It is cardiovascular renal disease to which for convenience we have given the name arteriosclerosis.

The cardinal symptoms of arteriosclerosis are hard to define because the disease is not a symptomal disease. Nature provides a margin of safety in the heart, bloodvessels, and kidneys that is very wide. So the heart is very badly damaged, the kidneys are very defective, and the bloodvessels are greatly thickened before nature complains. Thus the person with arteriosclerosis has no symptoms in the earlier stages of the disease. He has certain objective signs which may be discovered by examination.

As far as I know, the first symptom of arteriosclerosis is pain in the chest on exertion after eating. The quickest way to relieve this pain is by treating the heart. Nitroglycerin properly administered acts almost like magic in this type of cardiac pain.

This disease is not found in any of the textbooks, but I believe that a clear conception of its nature as a general disease that attacks so many people is of great importance. I know that it is of great importance to me in my work, which is limited to cardiovascular renal disease. When I treated kidneys, I never helped my patient. When I treated the heart, I never helped my patient. When I tried to soften the arteries I did my patient a good deal of harm. But since I have treated the body as a whole, and regarded the sufferers as victims of disturbed metabolism, I am sure the hygienic measures that I have advised have helped a great many of them.

Thus it would seem that the disease called arteriosclerosis, which is really cardiovascular renal disease, is primarily due to a disturbance of metabolism extending over a long period of time. This disturbance of metabolism consists in a sensitization of the cells of the body to particular proteins ordinarily found in food. Meat proteins are most often to blame. Fish proteins are somtimes to blame. Egg proteins are also harmful to a good many people. This process is subsymptomal for five, ten, or fifteen years until such time as a sufficient number of cells have been destroyed to impair the functionsof the organs. This gives rise to symptoms and the disease is discovered.

The remedy in this disease is to be found in the discovery and removal from the dietary of the offending proteins, meat being most common, and in the correction of metabolism by physical methods, particularly exercise. Exercise is the greatest stimulant of metabolism there is. Exercise makes

the patient breathe deeper, it helps the digestion of food, and stimulates the kidneys. It is the great stimulant of metabolism. Exercise has an important place in the treatment of arteriosclerosis. First diet and then exercise. The third important thing is attention to the intestinal tract.

We cannot throw overboard all that has been said of late years as to autointoxication, intestinal stasis, and all these things, but there is a remedy that is the best for dealing with the intestinal condition. Serial doses of castor oil, out-of-door exercise, and diet from which the offending proteins have been removed intelligently, so that there is no protein starvation, lead to a condition of improvement that makes futher attention to the question of autointoxication unnecessary.

This is the cellular theory of arteriosclerosis, with the hygienic treatment that logically follows its adoption.

In addition to this, we have to treat the sick person. The general plan of treatment—the diet, out-of-door exercise, and so on—is the underlying basis, but you have to treat the individual. When there is cardiac pain, attend to that.

The dilated heart, provided that there are symptoms of heart failure, must be taken care of with digitalis. The kidneys do not require any direct regimen. The psychical side of these persons is very important—they need reassurance.

Castor oil.—Is recommended in the *Indian Medical Gazette* as an admirable dressing for abrasions, slight burns, small wounds, and the like. Sometimes applications of tincture of iodine precede. It is even believed to be antiseptic.—*Med standard.*

Lime in the Eye.—Do not stop to remove the lime, but quickly drop into the eye a little water to which has been added an equal quantity of vinegar or lemon juice. Do not wait to reach a surgeon, otherwise the eye may be seriously damaged. The lime must be neutralized at once. Even then the ulcers will likely be several days healing.—*Health and Temperance.*

Analysis of 400 Cases of Lobar Pneumonia.—By J. G. Gross.—Lobar pneumonia is more fatal than it was formerly. Hospital records give less favorable results than those obtained from private practice, because among hospital patients there is less intelligent cooperation, there is a greater incidence of acute and chronic alcoholism, and the patients are less well nourished in general. Not only does the frequency of the disease vary in different seasons and in the corresponding seasons in different years, but the mortality is much greater at some times than at others from factors not yet understood. The mortality in patients under five years of age is about four times as great as in those between five and ten years old, which period marks the lowest mortality of all. After this each decade of age shows an increase in mortality over the preceding. In 125 cases in which the exact date of onset was known, it was found that there was no regularity in the day on which the crisis occurred, although it occurred by the tenth day in eighty per cent. In the remaining twenty per cent. it occurred on some later day up to one month after onset. In forty-six per cent. of the cases the first symptom was a chill, fourteen per

cent. began with pain in the chest, side or back and in twelve per cent. cough was the initial symptom. In sixty-three per cent. of 369 cases both albumin and casts were present in the urine. In 333 cases the site of the lesion was determined. The right upper lobe was affected in nine per cent. the right lower in twenty-nine per cent., the right middle in two per cent., the left upper in six, and the left lower in twenty-six per cent. With leucocyte counts below 10,000, the death rate was high; between 10,000 and 15,000 and between 20,000 and 25,000 the mortality was average, and between 15,000 and 20,000 there was an unexplained fall in the death rate. Counts above 25,000 gave a very low mortality. With counts up to 20,000 the proportion or terminations by crisis and lysis was fairly uniform between 20,000 and 25,000 the two terminations were about equal, and counts from 25,0000 to 30,000 showed a preponderance of one to two in favor of lysis.—*Jour A. M. A.*

Prognosis in Cardiovascular Disease.—By Thomas E. Satterthwaite. —In valvular disease the state of the vessels has an important bearing on the prognosis. The most important points are the character of the disease, its location, variety, extent, duration, and complications; the degree of myocardial implication; associated constitutional disease; patient's age, sex, status in life, habits, occupation. Only partial recovery can be looked for in organic cases, although the function may be restored almost completely. In infants under one year the outlook is particularly unfavorable in any form of heartdisease. Women apart from the special risk in pregnancy and parturition have a better expectation of life. In men the prognosis is most unfavorable where the occupation calls for physical strain or exposure to inclement weather. The outlook is more favorable in mitral insufficiency than in any other form of valvular disease and it is not incompatible with a long life. Mitral obstruction is more serious and seems to be more liable to the occurrence of embolism. The danger in aortic insufficiency depends on the presence or absence of arteriosclerosis or angina. Pulmonary valve disease is grave when congenital, while tricuspid obstructions are the most dangerous of all valvular diseases and the patients seldom live long. The intensity of a cardiac murmur is not a measure of the gravity or the extent of the disease process. Systolic murmurs are of less grave significance than diastolic. Heart cases are benefited by a suitable climate and the elevation should not be over 1,500 feet. Rest and avoidance of overdosing with drugs of the digitalis group are of great importance, while high blood pressure is always a bad sign even in the absence of interstitial nephritis. The diet should be carefully regulated and there should be no mental or physical strain and no overeating or overdrinking. Ascites is always an unfavorable sign, while kidney involvement usually hastens the end.—*Medical Record.*

Roentgen Diagnosis of Gastric Cancer.—By R. D. Carman (*American Journal of the Medical Sciences.*)—The records of the Mayo clinic show that in a large series of cases confirmed by operation, sixty-seven per cent. of the patients had palpable tumors and 53.3 per cent. had food remnants. In other words, thirty-three per cent. had no palpable tumors and 46.7 per cent. no food remnants. It is in the cases which show neither tumor

nor food remnants that the Rontgen rays have their greatest field of usefulness, and it is stated that in this clinic ninety-five per cent. of gastric carcinomas are discovered by this means. Since nearly one third of all cancers occur in the stomach, and since early recognition and operation alone afford a chance of cure, any measure which will increase the number of correct and early diagnoses is of the highest importance. The clinical data should always be known to the rontgenologist to stimulate his search or restrain the interpretation of his findings, and the diagnosis should be compatible with all findings. Occasionally the diagnosis can be made only through their correlation. The roentgenological signs in the order of their relative importance are: Filling defects, occasioned by the projection of the tumor into the barium filled lumen of the stomach producing irregularity of contour; alterations of pyloric function; perversion of peristalsis; altered motility; lessened flexibility; lessened mobility; diminished size; displacement. These are considered by the author in turn, with considerable attention to filling defects. The pictures produced by the different forms of cancer, fungous, scirrhous, mucoid, and carcinomatous ulcer are discussed. The experience of the examiner and his ability to see and interpret slight departures from the normal have some importance in the diagnosis of early cancers. One no larger than a cherry has been found and the discovery of smaller ones is possible. The cases reported illustrate the marked degree to which the indications and their combinations vary.

Correction of Depressed Fractures of the Nose by Transplant of Cartilage.—E. H. Beckman (*Surg., Gynec. and Obst.,* XXI, 6, 694.)—The author's operation, the technique of which is given below, is done with the view of correcting the depressed and lateral displacement of the nasal bones in cases of fracture with deformity due to lateral displacement.

He points out the facts that it is not necessary to use the transplants at once but they may be kept as many as five days; that the preservation of the perichondrium is not necessary for the success of the transplant.

The transplants were taken from the 7th rib at its sternal junction, this being the broadest and making it possible to leave a connection with the rib and sternum after removal of part of cartilage for transplant.

TECHNIQUE.

If in bad position, refracture nasal bones and apply splint for five to six days.

2. When nasal mucous membrane is intact make transplant.

3. Use wax model of defect as a guide to shaping transplant.

4. Incision one-fourth of an inch in length transversely through skin on nose between the two inner canthi.

5. With elevator separate skin and sub cutaneous tissue from bone to almost the tip. Do not elevate laterally.

6. Put transplant in place and suture at upper end to prevent upperward displacement of transplant.

7. Suture skin incision with horsehair.

J. G. Spackman.

Lesions of the Lumbo-sacro Iliac Region.—L. H. Langnecker (*J. Am. M. Ass.* LXV, 22, 1866.)—The author points out the fact that lesions of this region are the most frequent industrial and occupational diseases. That variations from the normal anatomical structure and relationship are frequent.

He has grouped the lesions into 3 classes. 1. Traumatic with and without anatomic variations. 2. Static. 3. Toxic.

The traumatic group are divided into acute and chronic. The acute type being the result of direct or indirect violence, as muscular action and would occur in heavy lifting etc. The result may be a tearing of the ligaments or a slip of the sacral articulations.

The symptoms and physical findings are—: Pain worse on all motions. May be referred to buttocks and down leg. Forward stoop, list to one side and leg flexed at hip. Obliteration of the normal lumber curve and slight bony prominence over the seat of injury.

The chronic type is the result of relaxed ligaments due to repeated strain or impingement of the broad transverse process of the 5th lumbar vertebra on the ilium.

There is local and referred pain. Unilateral deformity with slight forward bending. All movements are restricted.

The static group are due to faulty posture. The symptoms are gradual in onset. Pain worse on standing, lordosis, and backache are the most constant. There is abnormal mobility of the joint.

The toxic group represent lesions that are the result of either local or general infections. In acute cases the joint is swollen and tender. Severe pain on all motion. The chronic type is marked by dull pain which may be referred. It is relieved by posture. Forward bending and list to one side are common. Lumbar curve obliterated and all movements are restricted.

J. G. Spackman.

Perinephritic Abscesses.—Wm. F. Braasch (*Surg., Gynec. and Obst.* 1915. XXI, 631.)—Braasch divides perinephritic abscesses into two groups. (1.) True; those originating from a primary focus in the kidney. (2.) Subdiaphragmatic or those infections which are caused by neighboring foci in tissues other than the kidney. Retroperitoneal abscesses are also classed under this heading.

The following were found to be the etiological factors in order of frequency in a series of 67 cases of true perinephritic abscess. 1. Pyonephrosis. 2. Renal tuberculosis. 3. Nephrolithiasis. 4. Cortical abscess. 5. Traumatic rupture.

Of these, 19 cases belong to the first class. Of these 3 were long standing infected hydronephrosis. Nephrectomy was done in 10. Drainage and subsequent nephrectomy in 2. Drainage rendered subsequent nephrectomy much more difficult.

Class 2 comprised 10 cases. Prognosis poor. The abscess the result of a secondary mixed infection. 6 died within a few months after operation.

Class 3 contained 11 cases. The condition was secondary to a cortical abscess which was primarily due to stone. Continuous severe pain over

kidney was the most prominent symptom. Nephrectomy in 6. Nephrolithotomy and drainage in 5. The cases in which the abscess was directly connected with the cortical abscess healed by drainage with nephrectomy.

Cortical abscess 12 cases. There was pus in the urine of all except 2 which had perinephritic abscess communicating directly with the corticle one. 3 were cured by drainage. Recurrence 1. Nephrectomy done in cases of multiple cortical abscess.

Traumatic rupture 4. The abscess appeared from 2 to 3 weeks after rupture. Nephrectomy 3 cases. Drainage 1.

Of the 18 cases of subdiaphragmatic or retroperitoneal 2 had spinal involvement. Psoas abscess 1. Pelvic infection 1. of the remainder no data could be had as to the cause of infection.

The diagnostic methods employed were.

1. Repeated analysis of urine.
2. Bacteriologic examination of urine from the pelvis of both kidneys.
3. Renal function tests. Phenol-sulphone-pthalein.
4. X-Rays of urinary tract and thorax.

Conclusions: In large fluctuating abscesses with poor physical condition, drainage. If much renal involvement, drainage and nephrectomy if possible.

J. G. Spackman.

The End-Results of Seventy Cases of Renal Tuberculosis Treated by Nephrectomy.—E. G. Crabtree and H. Cabot (*Surg., Gynec. and Obst.* 1915, XXI, 669.)—Cabot in the introduction points out the fact that early operation is not attended with any better ultimate result than those of a more advanced stage. He believes that the danger of early operation is due to the lack of resistance in the patient. The cases which come to operation at a later stage have apparently developed a partial immunity.

The average length of time since operation was 5.6 years.

Sex. Equally divided. Women present a larger number of cures than men.

Age. Average was 34.9 years. Extremes 14 and 65.

Side Right 40. Left 27.

Family History. Definite history of exposure in 10 cases.

Negative 38. Not recorded 22.

Duration of Symptoms. Average 2½ years before operation.

Shortest period 3 weeks. Longest 10 years.

Presenting Symptom. i. e., Those first noticed by the patient. Most common by far was bladder irritability. 2. Pain on affected side. The remainder in order of frequency were loss of weight; pain in penis on urination; haematuria; chills and fever; colicky pain; acute retention from blood and pus.

THE CLINICAL SIGNS.

Temperature. In 46 cases the temperature fluctuated beween normal and 100. Two cases 102-104. Normal temperature 20 cases.

Urine. Slight traces of albumin 61. Negative 2. No urinalysis 7.

Pus and blood present in 60. History of haematuria 12. Macroscopic blood 10.

Other Tuberculous Lesions. Lung involvement 13. Died of this disease 6. Arrested lung involvement 1.

Tuberculosis of Epididymus. Previous to operation 3. Unilateral 2. Bi-lateral 1.

Tuberculosis of Prostate. Diagnosis made in 1 case. Negative rectal examinations 14. Records insufficient as to remainder.

Tubercular Adenitis. Two cases in which it was present at time of operation.

Tuberculous Stricture of Urethera. Present in 1. of the total number of cases 27 per cent. had tubercular lesions other than the kidney, ureter and bladder.

Operation. All nephrectomics with partial ureterectomy. No attempt was made to sterilize the ureter.

The immediate mortality, i. e., those which died as the result of the operation and while in the hospital under observation 4 cases, making 3.8 per cent. The causes of death in late mortality in order of frequency were 1. General tuberculosis. 2. Lung tuberculosis. 3. Tubercular meningitis. 4. Miliary tuberculosis.

Wounds. Better result from suture with drainage.

New Lesions after Operation. In the order of frequency were epididymitis, pulmonary, prostate, vesicle, larynx, remaining kidney, and urethra. The most prominent symptom after operation was frequency which lasted 2 years or more.

Sixty per cent of the series can be considered cured. The remainder still retain some evidence of the disease.

J. G. Spackman.

Differential Diagnosis of Chronic Appendicitis.—Bischoff (Dusseldorf) says it is often difficult to determine in disease of the right adnexa whether the appendix is also affected. Some years ago Basteds proposed to distend the colon by means of a rectal tube. If the appendix is affected the patient experiences pain in the region of the appendix, sometimes radiating to the navel. With normal appendix only a sensation of fulness is experienced, occasionally also some sensations between the navel and symphysis. Moderate distention only is necessary. Bischoff has tested this prcedure in thirty-seven cases. In twenty three positive cases chronic appendicitis existed, with adhesions, constrictions, stenosis etc. In fourteen negative cases the appendix was not affected. In six cases of adnexal disease the non-involvement of the appendix could be demonstrated. Even in pyosalpinx with intestinal adhesions, the case responded negatively to the test and the appendix was found to be normal. One case of apparent chronic appendicitis, reacting negatively, cholelithiasis was found. The method is also of value in differentiating between appendicitis and neuralgia.—*Monatsschr. f Geb. u. Gyn.* Vol. 40—398.

Theodore J. Gramm, M.D.

The Corpus Luteum.—Seitz. Wintz. and Frigerthut have made an

extensive study of the corpus luteum and have reached the following conclusions: Menstruation is dependent upon the function of the corpus luteum. It contains two bodies, one is the luteolipoid which has haemostatic properties and if given subcutaneously before or during the menses it diminishes and shortens the period of bleeding. The second body is lipamin, a lipoproteid and in fact a lecithen albumin. In animal experiments it favors the growth of the genitalia, and if given subcutaneously in amenorrhoea it brings on menstruation. Luteolipoid and lipamin are antagonistic and regulate the course of menstruation. Therapeutically luteolipoid acts admirably in the hemorrhages at puberty and in menorrhagia without organic lesions. In climacteric hemorrhages it only acts when coagulation is delayed. It is without effect in hemorrhages of inflammatory origin. In myoma there is even a transient increase of hemorrhage. In dysmenorrhoea with free bleeding, luteolipoid has a favorable action upon the pains.

Lipamin, when used sufficiently long, may induce menstruation in amenorrhea. It is warranted to attempt to remove hypoplasia of the genitalia by repeated injections of lipamin. In dysmenorrhea with scanty bleeding, lipamin given hypodermically before the period, appears to ameliorate and remove the pain.—*Abstr. Zemtralbl f. Gyn.* 1914,—1431.

THEODORE J. GRAMM, M.D.

THE DANGERS OF THE TAMPONADE IN OBSTETRIC AND GYNECOLOGICAL PRACTICE.—Weber (Munich) has studied this subject from its bacteriological side. In eighty-two cases of uterine atony treated with the intrauterine tampon 6.5 per cent. more became sick than after other methods of treatment. In placentapraevia the results were especially bad if any other manipulation preceded the tamponade. This was particularly true if the latter procedure was performed in the private house. The bacteriological examination showed that if the gause remained for ten hours within the uterine cavity the germ content was enormous. If it remained only from four to seven hours the germs were much fewer; and if the uterine cavity was previously sterile as in vaginal caesarian section the tampon was sterile after remaining sèven hours. If however other manipulations have been used before, the tampon contained numerous germs even after four or five hours. In extra peritoneal caesarian section, the absence of germs continued not longer than from two to six hours. The same results were found after abortion. No material difference was found when the gause was impregnated with substances such as iodoform. The bactericidal powers of gause seemed to be most increased after saturation with 5 per cent. hydrogen peroxid.—*Abstr. Zentralbl f. Gyn.* 1914,—416.

THEODORE J. GRAMM, M.D.

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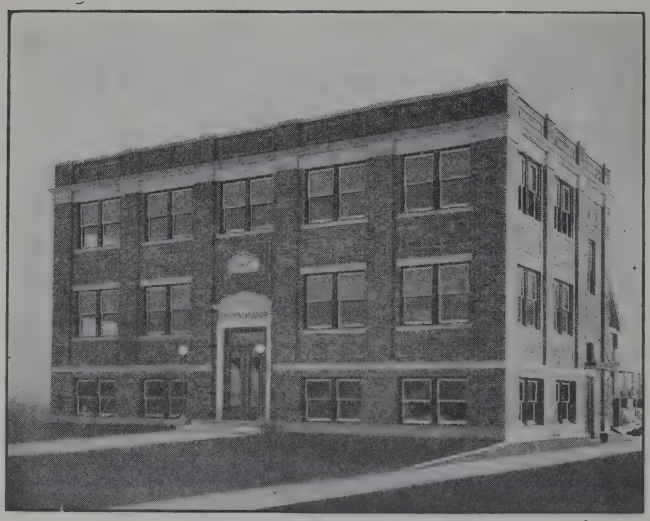

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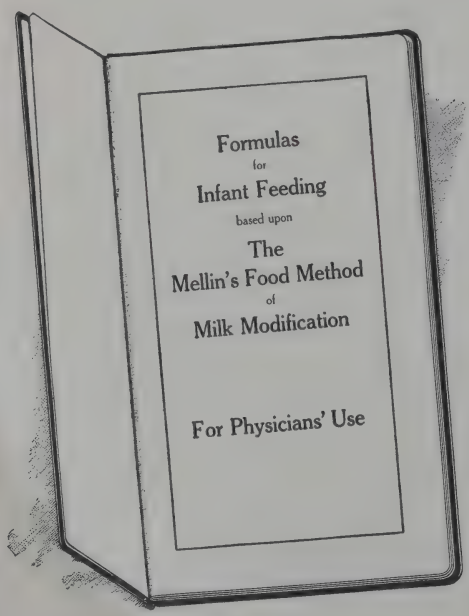

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THE HAHNEMANNIAN MONTHLY

NEWS AND ADVERTISER

A Medical Newspaper

JANUARY, 1916

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Principles and Practice of Obstetrics. By Joseph B. De Lee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School. Second edition, thoroughly revised. Large octavo of 1087 pages, with 938 illustrations 175 of them in colors. Philadelphia and London; W. B. Saunders Company, 1915. Cloth, $8.00 net; Half Morocco, $9.50 net.

The publicity attained by the publication of this work two years ago has been so great that a second edition is now called for. The work owes its value, first, to the thoroughness with which the subject is presented, and, second, to the practical and lucid manner in which the author has expressed his views in the text. Diagnosis has been made a special feature and the relations of obstetrical conditions and accidents to general medicine and surgery, have been brought out throughout the entire work. The author has borne in mind the practical needs of the student and of the medical practitioner. The subject matter is divided into four parts: "The Physiology of Pregnancy and the Puerperium"; "The Conduct of Pregnancy, Labor and the Puerperium"; "The Pathology of Pregnancy, Labor and the Puerperium," and "Operative Obstetrics." No review of this work would be complete without a reference to the illustrations of

which there are nine hundred and thirty-eight in all; one hundred and seventy-five of them being in colors. These illustrations have been prepared by experienced artists and are selected with a view of making clear the thoughts conveyed in the texts. Both the author and the publishers are to be complimented upon this valuable addition to medical literature.

International Clinics. A Quarterly Review of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, etc., etc. By leading members of the Medical Profession throughout the world, edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of Chas. H. Mayo, M.D., Rochester, Minn.; Sir Wm. Osler, M.D., Oxford, England; A. McPherson, M.D., Toronto; Frank Billings, M.D., Chicago; John A. Witherspoon, M.D., Nashville; John C. Clark, M.D., Philadelphia, Pa.; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harrold, M.D., London; Richard Kretz, M.D., Vienna, etc., etc. Vol. III. Twenty-fifth series, 1915. J. B. Lippincott, Philadelphia and London.

This volume of International Clinics contains a number of practical articles, among which may be mentioned the "Cause and Cure of Chronic Otitis Media," by S. E. Pendexter; "Therapeutic Technique," by William Brady, M. D.; "The Venous Pulse as an Aid in the Diagnosis of Heart Disease," by Thomas E. Satterthwaite, M.D.; "Observation ou the Physical Treatment of Diseases of Childhood," by William B. Snow, M.D.; "Hypophysis Disease in Children," by Allen D. Kavanal, M.D. L. Rahm contributes a very interesting article on "War Experiences and Observations in Germany and France."

Manual of Embryology. By A. Melville Paterson, M.D., F.R.C.S., Professor of Anatomy in the University of Liverpool, etc., etc., London: Henry Frowde and Hodder & Stoughton, Oxford University Press, Warwick Square, E. C.; 35 West 32d street, New York. Price, $2.75.

The importance of a broad basis for future practical work of the medical student is more and more being recognized. It is not surprising then that embryology is given an important place in relation to the problems of human anatomy and physiology. Prof. Patterson has prepared the present work with the full understanding of the need of the medical student and, in addition to considering the subject of general embryology, has taken up a careful consideration of all the various organs and tissues of the body. The work abounds in numerous illustrations and the text is arranged in such a manner as to bring into strong emphasis the important facts. It is a volume which can be highly recommended to teachers and students as both practical and authoritative.

Horlick's "Original" Malted Milk—A Nutritious Food Drink.—The orinigal achievements of a nation, a business concern or an individual, are always interesting from a human interest standpoint, and the history of Horlick's Malted Milk Company from the time this company placed their first food product upon the market, over a third of a century ago to the present time, is particularly interesting.

Many old-time druggists will recall Horlick's Food. For a time this product enjoyed a large sale, but Mr. Wm. Horlick, realizing the great

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disadvantage of all foods for infants that required the addition of fresh milk to complete them, owing to the difficulty of obtaining fresh milk, experimented for years with the view of perfecting a pure food product containing a proper proportion of pure, rich milk—a food that would be complete in itself, that would keep indefinitely in any climate, that would be free from all the dangers arising from the use of milk that is impure, adulterated, laden with disease germs, etc., and to have this food absolutely safe, very nourishing, easily digested by the most delicate infant or invalid, and at the same time contain all the elements of nourishment necessary to sustain life.

From its inception, Horlick's Malted Milk took first rank of all prepared foods. The medical profession at once recognized its many advantages and prescribed it largely, making it their first choice where a safe, delicate and nourishing diet was the desideratum.

By virtue of its unique advantages and intrinsic value coupled with trade co-operation and liberal, persistent advertising, Horlick's Malted Milk is in greater demand and enjoys a much larger sale than any other food product, for infants and invalids.

New Sanitarium.—Dr. Robert Lippincott Walter announces the severance of his connection with the Walter Sanitarium at Walters Park, Pa. He is now engaged in a like business at Doylestown, Pa., where he has established Linden, a convenient and ideally located institution where physicians can send their patients and be assured of ethical treatment.

Dr. Walter is prepared to give the various forms of baths, electricity and massage given by experienced operators, while the best of home cooking and the careful attention to the especial needs of the various individuals make it a place very desirable to both the doctor and the patient. No objectionable nor contagious cases admitted.

PENNSYLVANIA STATE NOTES.

Ralph Bernstein, M.D., State Society Editor.

The Homœopathic Medical Society of the County of Philadelphia held its regular monthly meeting at Hahnemann College, Thursday evening, Dec. 9, 1915, at 8.30 o'clock. Dr. W. A. Dewey, of the University of Michigan, delivered an exceptionally fine address, the title of which was "Materia Medica." Many interesting topics were discussed at this meeting by a large number of members present.

J. M. Kenworthy, M.D., Secretary.

The Clinico Pathologic Society of Philadelphia held its regular monthly meeting at Hahnemann Medical College, Saturday evening, Nov. 20, 1915, at 8.30 o'clock. The scientific program consisted of the following:

"Keratitis Neuro-paralytica" (Patient), F. O. Nagle, M.D.

"Calcification of the Tube and Ovary" (Specimen), N. S. Betts, M.D.

"Carcinoma of the Tongue, Inferior Maxilla and Sublingual Lymphatics," D. Roman, M.D.

"Gastric Ulcer with Perforation," J. D. Elliott, M.D.

"Aortic Aneurysm" (Patent), C. D. Saul, M.D.

"The India Ink Method of Demonstrating the Spirochete of Syphilis" (Specimen), J. G. Wurtz, M.D.

Applicants for membership should sign the following blank and forward with check for Five Dollars to Dr. W. N. Hammond, 313 Weightman Building, Philadelphia, Pa.

THE HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA

Application for Membership

Any Physician of good moral character, who has received the degree of Doctor of Medicine from some regularly incorporated Medical College, and who subscribes to the doctrine "SIMILIA SIMILIBUS CURENTUR," may be elected a member of this Society, upon recommendation of the Board of Censors.
Five dollars a year.

The undersigned, a graduate of ..... *of the year* ....., *and practicing medicine at* ..... *in the county of* ....., *State of Pennsylvania, hereby makes application for membership in the Homoeopathic Medical Society of the State of Pennsylvania, and agrees to abide by its Constitution and By-Laws if elected a member.*

....., *M. D.*

Vouchers ....., *M. D.*

....., *M. D.*

Members.

Please name the Hahnemannian in corresponding with our Advertisers.

"Blood Transfusion in Pernicious Anemia," S. W. Sappington, M.D.
"Ectopic Gestation" (Specimen), F. J. Frosch, M.D.
"Auricular Fibrillation" (Patient), W. R. Williams, M.D.
The meeting was an enjoyable one and was well attended.

B. K. Fletcher, M.D., Secretary.

The Philadelphia Society for Clinical Research held its regular monthly meeting at the office of Dr. J. E. James, 118 South 19th street, at 9 P. M. A large number of members were present at this meeting, all of whom had the pleasure of listening to many interesting topics which were discussed.

E. G. Muhley, M.D., Secretary.

The Society of Surgery, Gynecology and Obstetrics held its regular monthly meeting at Hahnemann College, Wednesday evening, Dec. 22, 1915, at 8.30 o'clock. Following is the program which was presented:

"An Unusual Case of Hematuria Complicating Pregnancy"; "The Cystoscopic Detection of Ureteral Calculus", L. T. Ashcraft, M.D.

"A Surgical Paper," H. P. Leopold, M.D.

Several interesting clinical cases were reported, after which a hearty discussion took place.

J. M. Kenworthy, M.D., Secretary.

The Women's Homœopathic Medical Club of Philadelphia held its regular monthly meeting at the office of Dr. Mary Branson, 1504 Locust street, on Tuesday evening, Nov. 2, 1915, at 8.30 o'clock. The meeting was an enthusiastic one, the election of officers to serve for the ensuing year took place, after which many interesting papers were read and discussed.

V. Reel, M.D., Secretary.

The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties held their regular monthly meeting at the Hotel Walton, Philadelphia, Pa., on Tuesday, Dec. 14, 1915. Luncheon was served to a large number of members and visiting physicians at 1.3 o'clock. An exceptionally fine paper on "The Value of Materia Medica" was read by Dr. E. M. Howard, of Camden, N. J. Several interesting addresses were made and a number of clinical cases were discussed. The meeting which proved to be a thoroughly enjoyable one was well attended.

Isaac Crowthers, M.D., Secretary.

The Hahnemannian Medical Society of Reading, Pa., held its regular monthly meeting at the Berkshire Hotel, on Nov. 11, 1915. The meeting was preceded by a dinner in honor of Dr. Clarence Bartlett, of Philadelphia, Pa., who was their guest. Following the dinner the business of the Society was disposed with after which the members had the pleasure of listening to the paper presented by Dr. Bartlett, the title of which was "Diabetes." A lengthy discussion followed. The censors reported favorably the name of Dr. Glen Knave.

E. K. Golding, M.D., Secretary.

The Blair County Homœopathic Medical Society held its regular monthly meeting at the Catfish Hotel, Hollidaysburg, Pa., on Thursday, Dec. 9, 1915. The physicians motored to the hotel, where an elaborate banquet was served at 7 P. M. Immediately following the banquet the business session took place, Dr. Palmer, of Hollidaysburg, presiding. Dr. B. F. Books, of Altoona, Pa., read a paper, the article being well received. The election of officers took place at this meeting which resulted in the following: President, Dr. Daniel Bohn, of Altoona, Pa.; vice-president,

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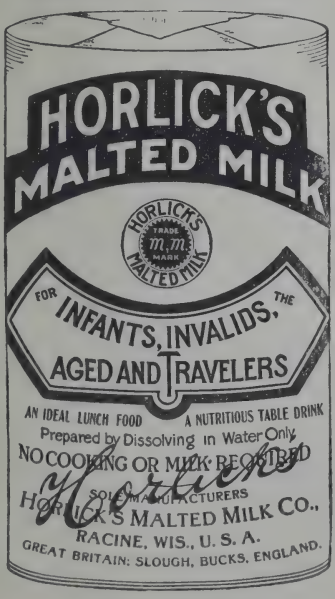
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Dr. W. J. Sharbaugh, Altoona, Pa.; secretary, Dr. J. W. Stitzel, Hollidaysburg, Pa.; treasurer, Dr. D. M. Roudabush, Altoona, Pa.; censors Dr. E. H. Morrow and Dr. A. L. Taylor, Altoona, Pa., and Dr. R. L. Piper, Tyrone, Pa. Before adjournment the physicians discussed plans for the coming year and a committee consisting of Doctors J. W. Stitzel, of Hollidaysburg, Pa.; B. F. Books, and H. B. Replogle was named to outline the work for 1916.

The Homœopathic Medical Society of the Twenty-third Ward of Philadelphia held its regular monthly meeting at the Pen and Pencil Club, 1026 Walnut street, on Wednesday, Dec. 15, 1915, the members being the guests of Dr. Ralph Bernstein. All business matters having been transacted the members listened intently to a lecture on "Diseases of the Skin," with lantern demonstration by Dr. Bernstein. The meeting was well attended and an ejoyable time was had by all present.

J. D. Boileau, M.D., Secretary.

PERSONALS.

Division No. 1, Knights Templar of Pennsylvania held their fifteenth annual field day at Fairmount Park, Philadelphia, Sept. 25, 1915. Corps Hospitaller were as follows: Chief, E. Sir Henry G. Bruner, M.D.; Staff, Sir E. A. Creuger, M.D.; Sir William W. Burns, M.D.; Sir Charles H. Harvey, M.D.; Sir David Henry, M. D.; Sir G. E. Levis, M.D.; Sir G. W. Deitz, M.D.; Sir W. H. Cowgill, M.D.; Sir F. P. Wilcox, M.D.; E. Sir J. C. Egbert, M.D.; Sir F. C. Hammond, M.D.; Sir E. G. Whinna, M.D.; E. Sir P. N. K. Schwenk, M.D.; Sir C. L. Hawkins, M.D.; Sir C. E. Ruffle, M.D.; Sir D. W. Levy, M.D.; E. Sir R. P. Mercer, M D.; E. Sir I. Crowthers, M. D.; E. Sir L. E. Marter, M.D.; Sir H. J. Feit, M.D.; Sir J. H. Closson, M.D.; Sir C. H. McDevitt, M.D.; Sir A. W. Gregg, M.D.; Sir Oscar Dicks, M.D.

Announcement is made of the marriage of Dr. Homer H. Snyder, of Scranton, Pa., and Miss Hannah J. Coate, chief dietician of Hahnemann Hospital, Philadelphia, the ceremony being performed by the Rev. Matthew Hyndmann, pastor of the Olivet Presbyterian church, Twenty-second and Mt. Vernon streets, Philadelphia. Dr. Snyder was an interne at Hahnemann Hospital and it was there that he first met Miss Coate, who is a native of Ludlow Falls, Ohio.

Dr. Albert Rowland Garner announces the opening of an office for the treatment of Mental and Nervous Diseases, at 2010 Chestnut street, Philadelphia. Office Hours: 1 to 2 P. M.

Dr. Edward K. Golding announces the removal of his office from 115 South Sixth street to 211 North Sixth street, Reading, Pa. Practice limited to uro-genital and venereal diseases. Office Hours: 9 A. M. to 1 P. M.; 7 P. M. to 8 P. M.; Sunday by appointment.

Married.—Mrs. Emil Cauffman announces the marriage of her daughter Helene Ormond Butler to Dr. Fred C. Emrey, on Tuesday, the seventh of December, 1915, in the city of Philadelphia.

To Physicians.—A good homœopathic physician can secure the offices of a physician recently deceased, situated in Reading, Pa. This is a rare opportunity. Has been a physician's office and location for more than thirty years, and has always done a good business. The offices can be had including second story front bedroom with use of bath, etc., on very reasonable terms if taken soon. Address, Miss M. C. JENNINGS, 137 South Eighth St., Reading, Pa.

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Tube-Point Package of Glycerinized Vaccine Virus Mulford, a sterile point and hermetically sealed container combined.

The Mulford Tube-Point is the ideal container for glycerinized vaccine virus. It combines a hermetically sealed capillary chamber, which protects the vaccine from contamination, and a sterile scarifying point ready for use.

The Mulford tube-point container is unexcelled as a safe way of furnishing vaccine virus.

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COLLEGE NOTES

Hahnemann Medical College and Hospital of Philadelphia

Edited by C. Seaver Smith, '16

Trip Through Hospital.—On Tuesday, Nov. 23d, at one o'clock, the entire Freshman class, thirty-two in all, were ready for a tour of the hospital. Dr. Pearson led half of this brigade of alert young men, each with his hair slicked, a clean shave, and brim full of questions. The honor of leading the other half was conferred upon Dr. Fleming.

No doubt the surgeons, instructors and internes were awaiting the arrival of this illustrious body with fear and trembling lest their cherished institution would be censured by these medical connoisseurs.

The various dispensaries—medical, pediatric, pharmacological, eye, neurological, X-ray and surgical, were all visited in turn. The heads of the various departments were very kind and explained in a few words the advantages, methods of instruction and the practical use of his department.

The following was the usual conversation: Dr. Fleming or Dr. Pearson: "Dr. ———, these are this year's Freshmen. We would like you to tell them something of your department." Dr. ———: "Well, I don't know as there is much to say." This followed by an excellent brief on his department and "all of which you will learn more of in a couple of years. I guess that's about all, doctor." "Thank you, doctor, good-bye." "Good-bye," followed by a few faint echoes of good-bye from the Freshmen nearest the doctor, and the mob shuffles out to appear with wide eyes and gaping mouths at the next medical sanctum.

The clinical amphitheatre and a private operating room were visited before the descent to the first floor. The front offices, waiting room and wards were seen here, and then in the basement the departments of orthopedics, skin diseases, women's diseases, accident ward, and the "Bellevue Stratford" were visited in turn.

The next sojourn, through the Nurses' Home, was brief and incomplete as may be imagined, but comprehensive enough to show how in this building, as well as in the others, everything is of the best and kept in perfect order.

In the Women's Building the eyes of the Freshmen were opened to the wonderful care of even the ward patients and each offspring. The Freshmen donned white gowns in this building, giving some the impression that they were doctors, others masqueraders, and still others that they were attired for the night.

The laundry and boiler house gave the class an idea of the enormity of the buildings of and connected with the hospital.

After the men's dispensary had been visited the class was conducted back to College.

The class wishes to thank Dr. Pearson and Dr. Fleming for their kind guidance, the former especially for negotiating the arrangements.

From the outside the hospital may not look large, portentous or well equipped, but for the initial visitor, as were many of the Freshmen, the inside is a revelation. The size and number, as well as the equipment and maintenance of the buildings found between the College on Broad

and the office of the Hospital on Fifteenth street, makes one proud to feel that he or she is in any way connected with such an illustrious institution.

Here and There about the College.

Professor Herbert L. Northrop, while attending the recent meeting of the American College of Surgeons, held in Boston, reports the following: Dr. Chas. H. Mayo, the noted surgeon (old school) surprised even the homœopathic surgeons present at the congress by praising in no doubtful terms Samuel Hahnemann and the work which he did. Dr. Mayo declared that Hahnemann was at least eighty years ahead of his day in his bacterium and serum thoughts, and prophesies that the most modern methods of treatment are directed in accord with his views. Mayo further stated that the serum treatment of to-day is homœopathic in its application and effect.

Eighteen of the Faculty of the Hahnemann Medical College and Hospital are now members of the American College of Surgeons, which is a mixed college consisting of prominent surgeons of both schools. Sounds well for the surgeons from Old Hahnemann!

Dr. A. L. Smethers, president of the Southern Homœopathic Medical Association, at their recent meeting in Cincinnati, stated that the Southern States could supply good locations for all the graduates from all the homœopathic colleges for the next ten years; therefore, when you grad-nate, remember that opportunity awaits you in the Southland.

Hahnemann Medical College of the Pacific paid Hahnemann Medical College of Philadelphia a very gracious compliment, by granting Dean Pearson an honorary degree of Doctor of Medicine. Hurrah, for the Dean! More power to him!!

Owing to the generosity of Mr. Walter E. Hering, the donor of the Hering Laboratory of Research, and who believes in college publicity, we are going to have a series of lantern slides, which are being made of our College and Hospital, for the purpose of showing prospective students the advantages of attending the Hahnemann Medical College.

The Southern Homœopathic Association will pay the tuition of some medical student from the South next year, "in some homœopathic college."

Cincinnati and vicinity now have only fifty-three homœopathic physicians, and twice that number are needed. Bear this in mind, Seniors, when you graduate, and there are only three of them who make a specialty of surgery!

Dr. W. E. Riley, of Fulton, Missouri, will visit our college after Christmas, and he wants to persuade a few of our young men to locate in Missouri. Watch out for Dr. Riley; he has to be shown!

Mr. Edmund Allen has given the College $500, which will partly be used for apparatus for our physical laboratory. Thanks to Mr. Allen.

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Warranted against a break down for one year.

Other types of **High-Frequency Apparatus,** generating a perfect **Oudin** current, a true **D'Arsonval,** Thermo-Faradic, Thermo-Penetration, Fulguration, Auto-Condensation, Auto Conduction, Dia-Thermic, X-Ray.

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Dr. Harold P. Peckham, a graduate of last June, was the only man from this College who took the New York State Board examination this year. He was successful, and therefore maintained our average of 100 per cent.

Dr. Daniel P. Maddux, our loyal alumnus, and Chester's noted surgeon, has been reappointed a member of the Pennsylvania Bureau of Medical Education and Licensure. Three cheers for both the Governor and Dr. Maddux!!

Our working Dean is after fifty students for the pre-medical and freshmen classes next year. Every student must help. If you know of anyone at Prep. School who is interested in the study of medicine, hand in his name to Dr. Bernstein, the Dean's assistant, and he will soon be on the job.

Expelled for Fee-Splitting.—The first trial of a member of the Missouri State Medical Association on a charge of fee-splitting and offering to split fees was held recently by one of our component societies. The offender was found guilty by the Board of Censors and expulsion recommended. The report of the Censors was adopted by the society and the sentence carried out. The expelled member was also a Fellow of the American Medical Association, which affiliation he loses.

In attacking some evils the best way to abolish them is to apply the whole force of our strength against them at the outset. This was done in the agitation against fee-splitting; the practice immediately decreased in all parts of the State where it had been prevalent and has disappeared all together in some places where it had threatened to gain a foothold. We need not expect, however, that simple threats to punish offenders or prohibitory resolutions and laws will efface this blot on our escutcheon. We must do more than that—we must drive out of our ranks those who persist in dishonoring their profession and deceiving their patients.

It is now three years since the Association adotped the by-law against fee-splitting and the case mentioned above is the first prosecution for violation of the section. This seeming indifference is due not to the inactivity of the officers of the Association but to the fact that it has been difficult to obtain evidence supported by competent testimony. This evidence must, of course, come from some member who has knowledge of the offense and will produce documentary proofs to substantiate the charge—a step that is offensive and repugnant to the finer feelings of the honest practitioner. Therein lies the grip of the fee-splitter. Having Oslerized his own sense of honor by avarice and the greed for gold he gambles with fate against exposure by men of purer motives and higher ideals. But conditions are rapidly changing. The fee-splitter is finding himself ostracized by the respectable men in the organization and these men are beginning to understand that the only way to purify our ranks is to expose and punish offenders.

The trial and expulsion of the guilty member referred to above is a warning to others that an awakened profession will purge itself of members who defy the traditions and lower the tone of our profession.—Journal of Missouri State Medical Association.

Examination of Candidates for Assistant Surgeon.—United States Public Health Service.—Boards will be convened at the Bureau of Public Health Service, 3 "B" street, S. E., Washington, D. C., and at a number of the Marine Hospitals of the Service, on Monday, January 24, 1916, at 10 o'clock A. M., for the purpose of examining candidates for admission to the grade of Assistant Surgeon in the Public Health Service.

The candidate must be between 23 and 32 years of age, a graduate of a reputable medical college, and must furnish testimonials from two responsible persons as to his professional and moral character, together with a recent photograph of himself. Credit will be given in the examination for service in hospitals for the insane, experience in the detection of mental diseases, and in any other particular line of professional work. Candidates must have had one year's hospital experience or two years' professional work.

Candidates must be not less than 5 feet, 4 inches, nor more than 6 feet, 2 inches, in height, with relatively corresponding weights.

The following is the order of examination: 1, Physical; 2, Oral; 3, Written; 4, Clinical.

Candidates are required to certify that they believe themselves free from any ailment which would disqualify them for service in any climate.

Examinations are chiefly in writing, and begin with a short autobiography of the candidate. The remainder of the written exercise covers the various branches of medicine, surgery, and hygiene.

The oral examination includes subjects of preliminary education, history, literature, and natural sciences.

The clinical examination is conducted at a hospital.

The examination usually covers a period of about ten days.

Successful candidates will be numbered according to their attainments on examination, and will be commissioned in the same order. They will receive early appointments.

After four years' service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon. Passed Assistant Surgeons after twelve years' service are entitled to examination for promotion to the grade of Surgeon.

Assistant surgeons receive $2,000, passed assistant surgeons, $2,400, surgeons $3,000, senior surgeons $3,500, and assistant surgeon-generals $4,000 a year. When quarters are not provided, commutation at the rate of $30, $40, and $50 a month, according to the grade, is allowed.

All grades receive longevity pay, 10 per cent. in addition to the regular salary for every five years up to 40 per cent. after twenty years' service.

The tenure of office is permanent. Officers traveling under orders are allowed actual expenses.

For invitation to appear before the board of examiners, address, "Surgeon-General, Public Health Service, Washington, D. C."

University of California Creates Chair of Homœopathy.—Dr. Wm. Boericke has been appointed by the Regents of the University of California, Professor of Homœopathic Therapeutics in the Medical Department, the appointment to take effect January 1, 1916. Dr. Boericke is now touring the East, ascertaining the methods used in the homœopathic colleges in instructing in materia merica.

This is the first time in the history of the University that a homœo-

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The College also has the advantage of affiliation, for teaching purposes, with The Children's Homoeopathic Hospital, St. Luke's Homoeopathic Hospital, The West Philadelphia General Homoeopathic Hospital, Allentown Hospital for the Insane and Municipal Hospital for Contagious Diseases.

Special attention is directed to the Department of Materia Medica and Therapeutics. The munificent endowment of Mr. Walter E. Hering has established for all time the Constantine Hering Chair of Homoeopathic Materia Medica, Therapeutics and Pharmacology.

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W. A. PEARSON, M. D., Ph. D., Dean.
SAMUEL W. SAPPINGTON, M. D., Registrar.
JOHN J. TULLER, M. D., Secretary.

path per se has been appointed to the teaching staff, and to receive a full professorship is an honor of which Dr. Boericke may well feel proud. We may also feel assured that Dr. Boericke will acquit himself in the position with honor to our school. The task is no sinecure, for he will be closely watched by all the old school faculty, but far from deprecating we welcome it, for by conscientious and thorough work we may well hope to interest them in our specialty. The faculty of the medical school is composed of well-trained scientific men, and while some might be prejudiced, the majority are so thoroughly imbued with the spirit of research that a proper presentation of the subject would only invite their further investigation.

Let us not forget Hering and, indeed, the time is ripe for a second Hering, versed in laboratory technique and modern scientific exactness, to give homœopathy that verification by chemical and physical means which will render it acceptable to the modern medical student. With the facilities that are available at the University of California we court investigation, and if out of the West can come the enlightenment of the East, the more glory to our virile state that has the courage to give a place in the sun to all that seek the light of scientific verification.—Pacific Coast Journal of Homœopathy.

Resolutions Passed by The Southern Medical Association, at Dallas, Texas, Nov. 8-11, 1915.—Whereas, The President and the Honorable Secretary of War have announced in the public press that a scheme for the reorganization of the Army will be presented to Congress at its coming session, which will materially increase the military establishment, and

Whereas, We recall the indignant protests and criticisms of the Nation at the failure to provide adequately for the sick and wounded at the beginning of the Civil War and the Spanish-American War, and

Whereas, It is known that this failure was due to the lack of sufficient number of medical officers in the regular army and a means for increasing the medical establishment at the outbreak of war, and

Whereas, In spite of the lessons of the Spanish-American War, which were fresh in mind in the reorganization of the Army in 1901, the Medical Department was not properly increased and no provision was made for its expansion in time of emergency, and

Whereas, To correct the defects in the 1901 legislation, subsequent legislation was necessary in which the medical profession of the United States was called on to assist; therefore, be it

Resolved by the Southern Medical Association, in session at Dallas, Texas, that the Secretary of War be petitioned to make adequate provision in the reorganization of the Army about to be presented to Congress for a sufficient number of medical officers for the regular establishment, which provision should aggregate a proportion of medical officers of, at least, seventy-five hundredths of one per cent. of the enlisted strength of the Army, or such number as the Surgeon-General of the Army may deem necessary, and be it further

Resolved, That the Secretary be petitioned to make provision in this reorganization for the expansion of the Medical Department at the beginning of war, by calling into service in the Medical Reserve Corps physicians from civil life who have been instructed in their special duties as medical officers in our summer camps, and otherwise as the War Department may see fit.

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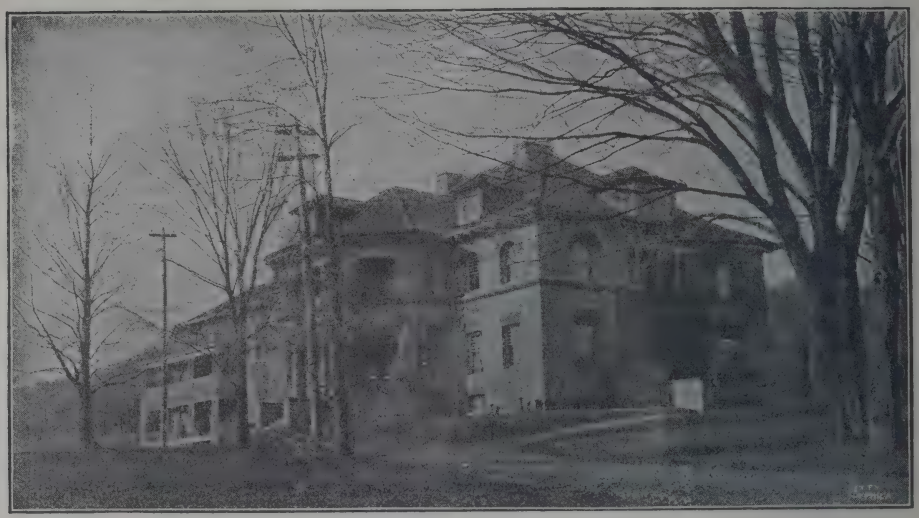

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